

1363
CERTIFICATE OF DEATH

01359

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 1/16/60	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Daniel Middle B. Last Bailey		4. DATE OF DEATH Month February Day 12 , Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/25/1878
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Salesman		10b. KIND OF BUSINESS OR INDUSTRY Watkins Products West Virginia	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Edgar Bailey		14. MOTHER'S MAIDEN NAME Mary Leatherman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT P.O. Box 599		Address Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocardial Degeneration 592X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Arteriosclerosis DUE TO (c) Chronic Nephritis		INTERVAL BETWEEN ONSET AND DEATH ? ? ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senile psychosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/16/60 , 19 60 , to 2/12/60 , 19 60 , that I last saw the deceased alive on 2/12/60 , 19 60 , and that death occurred at 6:45 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE James E. McLean		ADDRESS (Street, city or town, state) 49 Greene St. Cumberland, Md.	
PHYSICIAN'S NAME (Type) Dr. James E. McLean		DATE SIGNED 2/13/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Feb. 17, 1960	22c. NAME OF CEMETERY OR CREMATORY Beaver Run Cemetery	22d. LOCATION (City, town, or county) (State) Hampshire Co. W. Va.
23. FUNERAL DIRECTOR'S SIGNATURE Byron Kight		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR FEB 17 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

21
Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the information required by the law. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the information required by the law. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the information required by the law.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the information required by the law. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the information required by the law. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the information required by the law.

CERTIFICATE OF DEATH

County of _____ State of _____
I, _____, Clerk of the County of _____, do hereby certify that _____
of the County of _____ State of _____
was born _____ at _____
and died _____ at _____
the _____ day of _____ 19____
at the age of _____ years.
Signed and sealed this _____ day of _____ 19____
at _____
_____ Clerk of the County of _____
_____ Notary Public for the County of _____
State of _____

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G256 2-18-60 et
1364 CERTIFICATE OF DEATH

01360

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART HOSPITAL				d. STREET ADDRESS 505 1/2 N. CENTRE ST.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) JOSEPH		First		Middle BARNHILL		Last	
4. DATE OF DEATH FEB. 6 19 60		Month		Day		Year	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/6/93		9. AGE (In years last birthday) 66 66 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Paperhanger		10b. KIND OF BUSINESS OR INDUSTRY Own		11. BIRTHPLACE (State or foreign country) Lonaconing, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James P. Barnhill				14. MOTHER'S MAIDEN NAME Theresa Donnelly			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220 07 6608		INFORMANT Address Mrs. Theresa Haslbeck, Cumberland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Failure 434.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 48 hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma, esophagus; Stenosis, esophagus							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I for Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Cumberland, Md.		20g. (County) Cumberland, Md.		20h. (State) Md.	
21. I certify that I attended the deceased from 7/6 , 19 60 , to 7/6 , 19 60 , that I last saw the deceased alive on 7/6 , 19 60 , and that death occurred at 11:00 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) N. CENTRE ST., CUMBERLAND, MD. DATE SIGNED 7/9/60							
ACTUAL SIGNATURE Leo H. Lay Jr.		M.D.					
PHYSICIAN'S NAME (Type) LEO H. LAY, JR.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/9/1960		22c. NAME OF CEMETERY OR CREMATORY St. Patrick's Cem.		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Byron Kight				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR FEB 12 '60	
				24b. REGISTRAR'S SIGNATURE William E. Travis			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1875

James M. Chamberlain, Esq.
Boston, Mass.
Care of Mr. Chamberlain, Esq.
Boston, Mass.

1365 CERTIFICATE OF DEATH

Reg. Dist. No.

01362

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland	
c. LENGTH OF STAY IN 1b years		d. STREET ADDRESS 508 Dilly Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 508 Dilly Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ROBERT Middle GLISAN Last BEALL		4. DATE OF DEATH Month February Day 21 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 17, 1894
9. AGE (In years lost birthday) 65 yrs.		10. IF UNDER 1 YEAR Months 65 Days 65 Hours 65 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maint. Engineer		10b. KIND OF BUSINESS OR INDUSTRY F.O.E. Club Room	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Albert B. Beall		14. MOTHER'S MAIDEN NAME Christina Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. 213-12-9156	
17. INFORMANT J. Henry Stitcher		18. ADDRESS 508 Dilly Street, Cumberland, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Sclerosis DUE TO (c) 2 yrs PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2 yrs			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 21, 1960 to Feb. 21, 1960 , that I last saw the deceased alive on Feb. 21, 1960 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 236 Va. Ave., Cumberland, Md. DATE SIGNED Clay E. Durrett			
ACTUAL SIGNATURE Clay E. Durrett M.D. 236 Va. Ave., Cumberland, Md.			
PHYSICIAN'S NAME (Type) Clay E. Durrett M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 2/24/60	
22c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		24a. REC'D BY REGISTRAR DATE FEB 24 '60	
24b. REGISTRAR'S SIGNATURE Clay E. Durrett			

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1925 FEBRUARY 10

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

DATE 10-11-2004 BY SP-5 JAV/STW

EX-100-100000-100000

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1427 CERTIFICATE OF DEATH

02703

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b Lifetime	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 169 McCulloh Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Robert Middle Bean Last Bean		4. DATE OF DEATH Month 2 Day 26 Year 19 60	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 2 1887
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months 72 Days 72 Hours 72 Min. 72	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Store keeper		10b. KIND OF BUSINESS OR INDUSTRY Kelly Tire Co.	
11. BIRTHPLACE (State or foreign country) Frostburg		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Mark Bean		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-10-2735	
17. INFORMANT Mr. Aaron Bean, Son-Wright's Crossing		Address Frostburg, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332x Cerebral Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerosis. DUE TO (c) 30 yrs.		INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 23, 19 60 , to Feb 26, 19 60 , that I last saw the deceased alive on Feb 26, 19 60 , and that death occurred at 4:40 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Alvin J. Walters		ADDRESS (Street, city or town, state) 48 Broadway, Frostburg, Md. DATE SIGNED 2/29/60	
PHYSICIAN'S NAME (Type) Alvin J. Walters, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-29-60	
22c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Pk.		22d. LOCATION (City, town, or county) (State) Frostburg Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Paul M. Mattingly		24a. REC'D BY REGISTRAR DATE MAR 11 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

1957 CERTIFICATE OF DEATH

00785

1. Name of deceased: _____

2. Sex: _____

3. Race: _____

4. Date of birth: _____

5. Date of death: _____

6. Place of death: _____

7. Cause of death: _____

8. Signature of physician: _____

9. Signature of registrar: _____

10. Signature of informant: _____

11. Name of informant: _____

12. Address of informant: _____

13. Date of completion: _____

14. Registrar's office: _____

15. County: _____

16. State: _____

1428 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL on page nearest town) Frostburg				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital				d. STREET ADDRESS Douglas Avenue			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print)		First Homer Middle Edgle Last Beavers		4. DATE OF DEATH		Month February Day 12 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 12, 1895		9. AGE (In years last birthday) 64 yrs.	IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Miner		10b. KIND OF BUSINESS OR INDUSTRY Coal Mine		11. BIRTHPLACE (State or foreign country) Elk Garden, W.Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Beavers				14. MOTHER'S MAIDEN NAME Agnes Tasker			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 236-03-3826		17. INFORMANT Mrs. Hilda Beavers		Address Lonaconing, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Influenza 481X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) "Wife" DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 1 week
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Bronchial Asthma, Congestive heart failure							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 56 , to Feb 12, 1960 , that I last saw the deceased alive on Feb 11 , 19 60 , and that death occurred at 1 a M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) MAIN ST. DATE SIGNED 2-12-60							
ACTUAL SIGNATURE Leslie R. Miles Jr. M.D. MAIN ST.							
PHYSICIAN'S NAME (Type) LESLIE R. MILES JR. M.D. LONA CONING MD.							
22a. BURIAL, CREMATION, or other disposition (Specify) Burial		22b. DATE THEREOF 2/14/60		22c. NAME OF CEMETERY OR CREMATORY Bloomington Cemetery		22d. LOCATION (City, town, or county) (State) Bloomington, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn				ADDRESS Lonaconing, Md.		24a. REC'D BY REGISTRAR FEB 15 '60	
						24b. REGISTRAR'S SIGNATURE Arthur S. K...	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

• 2020/2021

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1366
1366 CERTIFICATE OF DEATH

01363

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 97 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND	
f. STREET ADDRESS 224 GELNN STREET		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LILIAH Middle "Keefe" Last BENNETT		4. DATE OF DEATH Month FEBRUARY Day 17 Year 19 60	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH JUNE 22, 1919
9. AGE (In years last birthday) 40 yrs.		10. IF UNDER 1 YEAR Months 3 Days 4 Hours 4 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Textile Wkr.		10b. KIND OF BUSINESS OR INDUSTRY Celanese Corp.	
11. BIRTHPLACE (State or foreign country) PENNSYLVANIA Chaneyville		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN H. KEEFER		14. MOTHER'S MAIDEN NAME ANNIE M. BROWNING	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 220p10-4202	
17. INFORMANT MEMORIAL HOSPITAL		Address CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis, general 154X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of Rectum DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 0			INTERVAL BETWEEN ONSET AND DEATH 3 1/2 3 1/2
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Aug 19 59 to 17 Feb 19 60 that (I) (we) last saw the deceased alive on 17 Feb 19 60 , and that death occurred at 6:45 PM from the causes and on the date stated above.			
22a. SIGNATURE Dr. Weisman		22b. DATE SIGNED 2/19/60	
22c. PHYSICIAN'S NAME (Type) DR. WEISMAN		22d. ADDRESS 59 S. Green St Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2/20/60	23c. NAME OF CEMETERY OR CREMATORY Mt. Zion Christian Cem	23d. LOCATION (City, town, or county) (State) Nr. Chaneyville, Pennsylvania
24. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		25a. REC'D BY REGISTRAR DATE FEB 23 '60	
25b. REGISTRAR'S SIGNATURE John J. Hafer			

3261

2/20/50

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DOI: 10.1002/for

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01364

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> 1367 MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>1/30/60</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Flintstone</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Sacred Heart Hospital</u>				d. STREET ADDRESS <u>RD #1</u>			
3. NAME OF DECEASED (Type or print) First <u>Ralph</u> Middle <u>Sylvester</u> Last <u>Bennett</u>				4. DATE OF DEATH Month <u>2</u> Day <u>12</u> Year <u>19 60</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-5-14</u>		9. AGE (In years last birthday) <u>46</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lumberman</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania Chaneysville</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Percy Bennett</u>				14. MOTHER'S MAIDEN NAME <u>Rebecca Robinette</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Patient's Chart</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Maceration of brain; right hemisphere</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Automobile accident</u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>12 days</u> <u>12 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accident struck another car</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>9:00</u> <u>P. m.</u> <u>Jan. 30</u> <u>1960</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Street</u>		20f. (City or town) (County) (State) <u>Flintstone, Alleg. Md.</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>B. Skitarelic</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>Dr. B. Skitarelic</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>February 2, 1960</u>		12/1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 15, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Chaneysville Meth. Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Chaneysville, Pennsylvania</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer, Cumberland, Maryland</u>				24a. REC'D BY REGISTRAR <u>FEB 15 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [REDACTED]</p>		<p>2. SEX [REDACTED]</p>	
<p>3. AGE [REDACTED]</p>		<p>4. DATE OF BIRTH [REDACTED]</p>	
<p>5. PLACE OF BIRTH [REDACTED]</p>		<p>6. OCCUPATION [REDACTED]</p>	
<p>7. MARITAL STATUS [REDACTED]</p>		<p>8. CAUSE OF DEATH [REDACTED]</p>	
<p>9. MANNER OF DEATH [REDACTED]</p>		<p>10. SIGNATURE OF EXAMINER [REDACTED]</p>	
<p>11. DATE OF DEATH [REDACTED]</p>		<p>12. TIME OF DEATH [REDACTED]</p>	
<p>13. PLACE OF DEATH [REDACTED]</p>		<p>14. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>15. SIGNATURE OF DECEASED [REDACTED]</p>		<p>16. SIGNATURE OF NEXT OF KIN [REDACTED]</p>	
<p>17. SIGNATURE OF PHYSICIAN [REDACTED]</p>		<p>18. SIGNATURE OF JURY [REDACTED]</p>	
<p>19. SIGNATURE OF CORONER [REDACTED]</p>		<p>20. SIGNATURE OF JUDGE [REDACTED]</p>	
<p>21. SIGNATURE OF CLERK [REDACTED]</p>		<p>22. SIGNATURE OF NOTARY [REDACTED]</p>	
<p>23. SIGNATURE OF DECEASED [REDACTED]</p>		<p>24. SIGNATURE OF NEXT OF KIN [REDACTED]</p>	
<p>25. SIGNATURE OF PHYSICIAN [REDACTED]</p>		<p>26. SIGNATURE OF JURY [REDACTED]</p>	
<p>27. SIGNATURE OF CORONER [REDACTED]</p>		<p>28. SIGNATURE OF JUDGE [REDACTED]</p>	
<p>29. SIGNATURE OF CLERK [REDACTED]</p>		<p>30. SIGNATURE OF NOTARY [REDACTED]</p>	

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>516 Broadway Circle</u>		d. STREET ADDRESS <u>516 Broadway Circle</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Eva</u> Middle <u>May</u> Last <u>Bett</u>		4. DATE OF DEATH Month <u>Feb</u> Day <u>9</u> Year <u>19 60</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 31, 1881</u>
9. AGE (In years lost birthday) <u>78</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Martin</u>		14. MOTHER'S MAIDEN NAME <u>Not known</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>INFORMANT</u>	
17. ADDRESS <u>516 Broadway Circle</u>		18. ADDRESS <u>Cumberland, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb. 9, 1960</u> to <u>Feb. 9, 1960</u> that I last saw the deceased alive on <u>Feb. 9, 1960</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Clayton L. Lunn</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>236 W. 1st Cumberland 7/10/60</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/12/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rosehill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Cumberland Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ruth E. Silcox</u>		ADDRESS <u>Cumberland Maryland</u>	
24a. REC'D BY REGISTRAR DATE <u>FEB 15 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

01005

CERTIFICATE OF DEATH

1908

Location

Residence

Age

Sex

Marital Status

Occupation

No. of Children

Cause of Death

Signature of Physician

Signature of Registrar

Signature of Informant

Signature of Witness

Signature of Coroner

Signature of Jury

Signature of Judge

Signature of Clerk

Signature of Sheriff

060

MEDICAL CERTIFICATION

01366

1. PLACE OF DEATH o. COUNTY ALEEGANY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Baby		4. DATE OF DEATH Month FEBRUARY Day 4 Year 1960	
5. SEX FEMALE		6. COLOR OR RACE WHITE	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH FEBRUARY 4, 1960	
9. AGE (In years last birthday) yrs. 1		10. IF UNDER 1 YEAR Months 1 Days 30	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		12. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME CHARLES E. BOHRER		14. MOTHER'S MAIDEN NAME ANNA BERGMANN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. None	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Obstruction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Aspiration of thick Amniotic Materials DUE TO (c) Postnatally			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4 Feb 19 60 , to 4 Feb 19 60 , that (I) (we) last saw the deceased alive on 4 Feb 19 60 , and that death occurred at 7:30 P M, from the causes and on the date stated above.			
22a. SIGNATURE Leland Ransom		22b. DATE SIGNED 4 Feb 60	
22c. PHYSICIAN'S NAME (Type) LELAND RANSOM M.D.		22d. ADDRESS 63 Greene St. Cumberland, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/5/60	
23c. NAME OF CEMETERY OR CREMATORY Baptist Cemetery		23d. LOCATION (City, town, or county) (State) Tarboro W. Va	
24. FUNERAL DIRECTOR'S SIGNATURE John H. Hafer		25. REC'D BY REGISTRAR DATE FEB 10 '60	
26. ADDRESS Cumberland Md		27. REGISTRAR'S SIGNATURE Arthur L. Hanks	

CENTRAL OF DEATH

ALLIANCE

WATKINS

WATKINS

WATKINS

FEBRUARY 1

FEBRUARY 1

FEBRUARY 1, 1900

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CERTIFICATE OF DEATH

Reg. Dist. No.

01367

1. PLACE OF DEATH o. COUNTY Allegany 1370 MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 40 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 549 North Mechanic St.		1 d. STREET ADDRESS 549 North Mechanic St.	
3. NAME OF DECEASED (Type or print) First Rosa Middle Anne Last Braithwaite		4. DATE OF DEATH Month Feb. Day 15 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 4, 1878
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Paw Paw, W.Va.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Daniel Alderton	
14. MOTHER'S MAIDEN NAME Mary Largent		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs. Elmo Evans, Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X Cerebral Hemorrhage DUE TO (b) Renal arteriosclerosis DUE TO (c) Renal arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 2 days years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 55 to Feb 15, 1960 that I last saw the deceased alive on Feb 15, 1960 , and that death occurred at 4:45 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE B. M. Schindler M.D.		ADDRESS (Street, city or town, state) 43 Green St, Cumberland, Md	
PHYSICIAN'S NAME (Type) Blane M. Schindler		DATE SIGNED 2/17/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 18, 1960	
22c. NAME OF CEMETERY OR CREMATORY Camp Hill Cemetery		22d. LOCATION (City, town, or county) (State) Paw Paw, W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.		24a. REC'D BY REGISTRAR FEB 23 '60	
24b. REGISTRAR'S SIGNATURE C. S. Evans			

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

01368

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY		1377 MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b LL DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Potomac Park, Cumberland			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL		d. STREET ADDRESS 395 Cresap Drive				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) LUCIUS C.		First Gary S.		Middle Bridgers		Last LL	
4. DATE OF DEATH FEB. 7 1960		Month FEB.		Day 7		Year 1960	
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/15/1887	
9. AGE (In years lost birthday) 72		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Clergyman		10b. KIND OF BUSINESS OR INDUSTRY Ministry		11. BIRTHPLACE (State or foreign country) Margarettsville, N. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Alvin S. BRIDGERS				14. MOTHER'S MAIDEN NAME MARY G COGGINS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No,		16. SOCIAL SECURITY NO. 219-34-6540		17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-vascular Accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO (c) 							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 1957 to Feb 7 1960 , that I last saw the deceased alive on Feb 7 1960 , and that death occurred at 1:28 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE George M. Simons		M.D. Algonquin Hotel		ADDRESS (Street, city or town, state) Cumberland, Md.		DATE SIGNED 2/9/60	
PHYSICIAN'S NAME (Type) DR. GEORGE SIMONS							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/10/60		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR DATE FEB 12 '60	
				24b. REGISTRAR'S SIGNATURE L. House			

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1372

Reg. Dist. No.

01369

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 62 DAYS			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACREDHEART HOSPITAL				d. STREET ADDRESS 424 N. MECHANIC ST.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First CHARLES Middle C. Last BRIGHT				4. DATE OF DEATH Month FEB. Day 25 Year 19 60			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH FEB. 8, 1900	
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STEEL WORKER				10b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION		11. BIRTHPLACE (State or foreign country) PA.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME HARRY BRIGHT (DECEASED)				14. MOTHER'S MAIDEN NAME IDA DOUGHERTY (DECEASED)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 193-01-9156		17. INFORMANT Patient's Chart, Sacred Heart Hosp.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis, generalized 199.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH Months
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Benedict Skitarellic				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Benedict Skitarellic, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> February 25, 1960			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF FEB. 29, 1960		22c. NAME OF CEMETERY OR CREMATORY MOUNT HOPE		22d. LOCATION (City, town, or county) (State) OKMONT, PA.	
23. FUNERAL DIRECTOR'S SIGNATURE H. WAYNE GEORGE,				ADDRESS CUMBERLAND, MARYLAND		24a. REC'D BY REGISTRAR FEB 29 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF NEW YORK - BUREAU OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF DEATH	
JAMES J. JONES		Male		35		White		1912	
6. PLACE OF DEATH		7. CAUSE OF DEATH		8. MANNER OF DEATH		9. SIGNATURE OF EXAMINER		10. SIGNATURE OF ATTENDING PHYSICIAN	
New York City		Heart Disease		Natural		[Signature]		[Signature]	
11. PLACE OF BIRTH		12. DATE OF BIRTH		13. DATE OF DEATH		14. TIME OF DEATH		15. TIME OF EXAMINATION	
New York City		1912		1912		10:00 AM		11:00 AM	
16. OCCUPATION		17. EDUCATION		18. MARITAL STATUS		19. PREVIOUS ILLNESS		20. PREVIOUS SURGERY	
None		None		Single		None		None	
21. SIGNATURE OF EXAMINER		22. SIGNATURE OF ATTENDING PHYSICIAN		23. SIGNATURE OF WITNESSES		24. SIGNATURE OF WITNESSES		25. SIGNATURE OF WITNESSES	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

1373 CERTIFICATE OF DEATH

Reg. Dist. No.

01370

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 18 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland Rt. # 5	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital				d. STREET ADDRESS Brant Rd, Cresaptown		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Carrie Middle R. Last Clayton				4. DATE OF DEATH Month 2 Day 1 Year 1960			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-8-83		9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Pendleton Co. W. Va.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James Barkley				14. MOTHER'S MAIDEN NAME Lea Teeter			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		INFORMANT Mr. Brooks H. Clayton		Address Cresaptown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary heart failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerotic heart disease DUE TO (c) generalized arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH 7 days 2 years 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-14 , 19 60 , to 2-1 , 19 60 , that I last saw the deceased alive on 1-31 , 19 60 , and that death occurred at 4:45 P.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE L. Brings				ADDRESS (Street, city or town, state) 57 Greene St.,		DATE SIGNED 2/2/60	
PHYSICIAN'S NAME (Type) Dr. L. Brings				Cumberland, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/4/60		22c. NAME OF CEMETERY OR CREMATORY Zion Memorial Burial Pk.		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George.				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR DATE FEB 5 '60	
						24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

01078

CERTIFICATE OF BIRTH

1913

Blank certificate form with faint lines and text, including fields for name, date, and location.

1374 CERTIFICATE OF DEATH

Reg. Dist. No.

01571

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 12/4/57	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Janette Middle Connor Last Connor		4. DATE OF DEATH Month February Day 29 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/8/1874
9. AGE (In years last birthday) 86 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Eckhart, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Charles Connor		14. MOTHER'S MAIDEN NAME Mary Ann Mathews	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
INFORMANT P.O.Box 599, Address Cumberland, Md.		Allegany County Infirmary Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Hypostasis 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Myocardial Degeneration DUE TO (c) Cerebral Arteriosclerosis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senile psychosis			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/4/57 , 19____, to 2/29/60 , 19____, that I last saw the deceased alive on 2/29/60 , 19____, and that death occurred at 11:30 A.M. the causes and on the date stated above. ADDRESS (Street, city or town, state) 49 Greene St. DATE SIGNED 2/29/60			
ACTUAL SIGNATURE James E. McLean M.D.		PHYSICIAN'S NAME (Type) Dr. James E. McLean Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-3-60	22c. NAME OF CEMETERY OR CREMATORY Eckhart Cemetery	22d. LOCATION (City, town, or county) (State) Eckhart, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Durst, Frostburg, Md.		24a. REC'D BY REGISTRAR DATE MAR 4 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11571

ALLEGANY COUNTY RECORDS

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Allegany County Records

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

01572

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write Westernport)		c. LENGTH OF STAY IN lb 80 Yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 422 Spruce		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mary Cook		4. DATE OF DEATH Feb. 10, 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 22, 1879
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Guy		14. MOTHER'S MAIDEN NAME Mary Presley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. INFORMANT Address Mrs. George Brode-Westernport, Md.	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis and Hypertension DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 Days 5 Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 8 , 19 60 , to Feb 10 , 19 60 , that I last saw the deceased alive on Feb. 10 , 19 60 , and that death occurred at 4:10 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 114 Ashfield St. Piedmont, W. Va. DATE SIGNED 2-12-60 ACTUAL SIGNATURE Paul R. Wilson M.D. PHYSICIAN'S NAME (Type) Paul R. Wilson, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/13/60	22c. NAME OF CEMETERY OR CREMATORY Philos	22d. LOCATION (City, town, or county) (State) Westernport Md.
23. FUNERAL DIRECTOR'S SIGNATURE E. J. Boral		24a. REC'D BY REGISTRAR DATE FEB 15 '60	
ADDRESS Westernport, Md.		24b. REGISTRAR'S SIGNATURE Charles S. Hines	

Page 4

death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death.

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the page from the papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01573

1. PLACE OF DEATH a. COUNTY ALLEGANY 1375 b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
c. LENGTH OF STAY IN 1b 13 HRS. 15 MIN.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND 02	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL-MEMORIAL & WARWICK AVES.		d. STREET ADDRESS 516 CONRAD AVENUE	
3. NAME OF DECEASED (Type or print) First JOHN Middle E Last COOPER		4. DATE OF DEATH Month FEBRUARY Day 1 Year 19 60	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOVEMBER 2, 1910
9. AGE (In years last birthday) 49		10. IF UNDER 1 YEAR Months 4 Days 9 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AGENT		10b. KIND OF BUSINESS OR INDUSTRY PRUDENTIAL LIFE INS.	
11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ERNEST COOPER		14. MOTHER'S MAIDEN NAME MARCELLA DERN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 214-10-5570	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction (Septal) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 24 hrs			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 2-1-1960 to 2-1-1960 that (I) (we) last saw the deceased alive on 2-1-1960 , and that death occurred at 10:25 PM from the causes and on the date stated above.			
22a. SIGNATURE William P. James		22b. DATE SIGNED 2-3-60	
22c. PHYSICIAN'S NAME (Type) DR. W. P. JAMES.		22d. ADDRESS 4411 Center St, Cumberland, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2/4/60	23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park	23d. LOCATION (City, town, or county) (State) Cumberland Maryland
24. FUNERAL DIRECTOR'S SIGNATURE Ruth E. Silcox		25a. REC'D BY REGISTRAR DATE FEB 8 '60	
ADDRESS Cumberland Maryland		25b. REGISTRAR'S SIGNATURE Arthur S. Hanes	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

1917

ALLIANCE

ALLIANCE

HARRIS

COOPER

COOPER

1712 1/2 N. 17TH

MEMORIAL HOSPITAL - 1712 1/2 N. 17TH

210 TOWNSEND AVENUE

FEBRUARY 1

COOPER

LEWIS

WHITE

MEMORIAL LIFE INS. CO. OF PENNSYLVANIA

AGENT

MARCELLA DEAN

THOMAS COOPER

MEMORIAL HOSPITAL - 1712 1/2 N. 17TH

Witnessed and attested

DR. W. D. JAMES

1376 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 1 week	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sylvan Retreat		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Fredrick Middle D. Last Dietz		4. DATE OF DEATH Month February Day 23 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/23/91
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR: Months 68 Days 68 Hours 68 Min. 68	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter Retired		10b. KIND OF BUSINESS OR INDUSTRY Self.	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Perry Dietz		14. MOTHER'S MAIDEN NAME Jenny Cessna	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, name; unknown) No		16. SOCIAL SECURITY NO. 320-03-7546	
17. INFORMANT County Infirmary Cumber Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 522 Pulmonary Hypertension DUE TO 592X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 422 Myocardial Degeneration DUE TO 592 Chronic Hepatitis (c) 300 Schizophrenia (Paranoid type)		INTERVAL BETWEEN ONSET AND DEATH 48 hrs. ? ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 16, 1960 to Feb. 23, 1960 , that I last saw the deceased alive on Feb. 23, 1960 , and that death occurred at M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE James E. McLean		ADDRESS (Street, city or town, state) 49 Greene St. Cumberland Md.	
PHYSICIAN'S NAME (Type) James E. McLean, M.D.		DATE SIGNED 49 Greene St., Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/26/60	
22c. NAME OF CEMETERY OR CREMATORY Green Mount Pk.		22d. LOCATION (City, town, or county) (State) Cumber Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc		ADDRESS Cumber Md.	
24a. REC'D BY REGISTRAR FEB 29 1960		24b. REGISTRAR'S SIGNATURE William S. ...	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

01-74

CERTIFICATE OF DEATH

1. NAME OF DECEASED [Faint text]		2. SEX [Faint text]		3. AGE [Faint text]	
4. DATE OF DEATH [Faint text]		5. TIME OF DEATH [Faint text]		6. PLACE OF DEATH [Faint text]	
7. CAUSE OF DEATH [Faint text]		8. MANNER OF DEATH [Faint text]		9. SIGNATURE OF PHYSICIAN [Faint text]	
10. SIGNATURE OF REGISTRAR [Faint text]		11. SIGNATURE OF WITNESS [Faint text]		12. SIGNATURE OF DECEASED [Faint text]	
13. SIGNATURE OF NEXT OF KIN [Faint text]		14. SIGNATURE OF BURIAL OFFICER [Faint text]		15. SIGNATURE OF CHURCH OFFICER [Faint text]	
16. SIGNATURE OF MINISTER [Faint text]		17. SIGNATURE OF CLERGYMAN [Faint text]		18. SIGNATURE OF OTHER [Faint text]	
19. SIGNATURE OF OTHER [Faint text]		20. SIGNATURE OF OTHER [Faint text]		21. SIGNATURE OF OTHER [Faint text]	
22. SIGNATURE OF OTHER [Faint text]		23. SIGNATURE OF OTHER [Faint text]		24. SIGNATURE OF OTHER [Faint text]	
25. SIGNATURE OF OTHER [Faint text]		26. SIGNATURE OF OTHER [Faint text]		27. SIGNATURE OF OTHER [Faint text]	
28. SIGNATURE OF OTHER [Faint text]		29. SIGNATURE OF OTHER [Faint text]		30. SIGNATURE OF OTHER [Faint text]	
31. SIGNATURE OF OTHER [Faint text]		32. SIGNATURE OF OTHER [Faint text]		33. SIGNATURE OF OTHER [Faint text]	
34. SIGNATURE OF OTHER [Faint text]		35. SIGNATURE OF OTHER [Faint text]		36. SIGNATURE OF OTHER [Faint text]	
37. SIGNATURE OF OTHER [Faint text]		38. SIGNATURE OF OTHER [Faint text]		39. SIGNATURE OF OTHER [Faint text]	
40. SIGNATURE OF OTHER [Faint text]		41. SIGNATURE OF OTHER [Faint text]		42. SIGNATURE OF OTHER [Faint text]	
43. SIGNATURE OF OTHER [Faint text]		44. SIGNATURE OF OTHER [Faint text]		45. SIGNATURE OF OTHER [Faint text]	
46. SIGNATURE OF OTHER [Faint text]		47. SIGNATURE OF OTHER [Faint text]		48. SIGNATURE OF OTHER [Faint text]	
49. SIGNATURE OF OTHER [Faint text]		50. SIGNATURE OF OTHER [Faint text]		51. SIGNATURE OF OTHER [Faint text]	
52. SIGNATURE OF OTHER [Faint text]		53. SIGNATURE OF OTHER [Faint text]		54. SIGNATURE OF OTHER [Faint text]	
55. SIGNATURE OF OTHER [Faint text]		56. SIGNATURE OF OTHER [Faint text]		57. SIGNATURE OF OTHER [Faint text]	
58. SIGNATURE OF OTHER [Faint text]		59. SIGNATURE OF OTHER [Faint text]		60. SIGNATURE OF OTHER [Faint text]	
61. SIGNATURE OF OTHER [Faint text]		62. SIGNATURE OF OTHER [Faint text]		63. SIGNATURE OF OTHER [Faint text]	
64. SIGNATURE OF OTHER [Faint text]		65. SIGNATURE OF OTHER [Faint text]		66. SIGNATURE OF OTHER [Faint text]	
67. SIGNATURE OF OTHER [Faint text]		68. SIGNATURE OF OTHER [Faint text]		69. SIGNATURE OF OTHER [Faint text]	
70. SIGNATURE OF OTHER [Faint text]		71. SIGNATURE OF OTHER [Faint text]		72. SIGNATURE OF OTHER [Faint text]	
73. SIGNATURE OF OTHER [Faint text]		74. SIGNATURE OF OTHER [Faint text]		75. SIGNATURE OF OTHER [Faint text]	
76. SIGNATURE OF OTHER [Faint text]		77. SIGNATURE OF OTHER [Faint text]		78. SIGNATURE OF OTHER [Faint text]	
79. SIGNATURE OF OTHER [Faint text]		80. SIGNATURE OF OTHER [Faint text]		81. SIGNATURE OF OTHER [Faint text]	
82. SIGNATURE OF OTHER [Faint text]		83. SIGNATURE OF OTHER [Faint text]		84. SIGNATURE OF OTHER [Faint text]	
85. SIGNATURE OF OTHER [Faint text]		86. SIGNATURE OF OTHER [Faint text]		87. SIGNATURE OF OTHER [Faint text]	
88. SIGNATURE OF OTHER [Faint text]		89. SIGNATURE OF OTHER [Faint text]		90. SIGNATURE OF OTHER [Faint text]	
91. SIGNATURE OF OTHER [Faint text]		92. SIGNATURE OF OTHER [Faint text]		93. SIGNATURE OF OTHER [Faint text]	
94. SIGNATURE OF OTHER [Faint text]		95. SIGNATURE OF OTHER [Faint text]		96. SIGNATURE OF OTHER [Faint text]	
97. SIGNATURE OF OTHER [Faint text]		98. SIGNATURE OF OTHER [Faint text]		99. SIGNATURE OF OTHER [Faint text]	
100. SIGNATURE OF OTHER [Faint text]		101. SIGNATURE OF OTHER [Faint text]		102. SIGNATURE OF OTHER [Faint text]	



Vertical text on the right margin, likely containing filing or administrative information, including dates and reference numbers.

1429 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b X Lonaconing	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital		d. STREET ADDRESS Hanekamp Street	
3. NAME OF DECEASED (Type or print) Jesse First Middle Last		4. DATE OF DEATH February 14 1960 Month Day Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 10, 1883 78 yrs.
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pulp Mill Employee		10b. KIND OF BUSINESS OR INDUSTRY Lonaconing, Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jesse Dohm		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Faye Dohm Address Lonaconing, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic glomerulonephritis 592x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) — DUE TO (c) — PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pneumococcosis and Virus pneumonia	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. INTERVAL BETWEEN ONSET AND DEATH 5 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 5 1960 to Feb 14 1960 , that I last saw the deceased alive on Feb 13 1960 , and that death occurred at 5 M, from the causes and on the date stated above.		21. ADDRESS (Street, city or town, state) DATE SIGNED 271 Main St, Lonaconing George Vash	
ACTUAL SIGNATURE George Vash M.D.		PHYSICIAN'S NAME (Type) George VASH	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/17/60	22c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery	22d. LOCATION (City, town, or county) (State) Lonaconing, Md.
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn ADDRESS Lonaconing, Md.		24a. REC'D BY REGISTRAR FEB 19 1960 DATE	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1925 CERTIFICATE OF DEATH

DATE OF DEATH

NAME OF DECEASED **George Johnson** SEX **Male** AGE **35** RACE **White**

DATE OF BIRTH **March 10, 1890** PLACE OF BIRTH **St. Louis, Mo.**

RESIDENCE **1234 North Broadway, Baltimore, Md.**

CAUSE OF DEATH **Heart Disease**

DATE OF DEATH **March 10, 1925** TIME OF DEATH **10:30 A.M.**

PLACE OF DEATH **Home**

DECEASED'S OCCUPATION **Unknown**

DECEASED'S RELIGION **Unknown**

DECEASED'S MARITAL STATUS **Single**

DECEASED'S EDUCATION **High School**

DECEASED'S PREVIOUS ILLNESS **None**

DECEASED'S PREVIOUS SURGERY **None**

DECEASED'S PREVIOUS TRAUMA **None**

DECEASED'S PREVIOUS TOXICITY **None**

DECEASED'S PREVIOUS INFECTION **None**

DECEASED'S PREVIOUS ALLERGY **None**

DECEASED'S PREVIOUS DRUGS **None**

DECEASED'S PREVIOUS ACCIDENTS **None**

DECEASED'S PREVIOUS OTHER CAUSES **None**

DECEASED'S PREVIOUS OTHER CAUSES **None**

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1430 CERTIFICATE OF DEATH

01376

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b X Lonaconing	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Rhoda		4. DATE OF DEATH Month February Day 15 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 7, 1898
9. AGE (In years last birthday) 61 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Lonaconing, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Alex Brown		14. MOTHER'S MAIDEN NAME Rhoda Beeman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Agnes Nines		Address Lonaconing, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 DUE TO Acute Cardiac failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis (c) Pneumonitis		INTERVAL BETWEEN ONSET AND DEATH 24 hours years 2 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Obesity			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 4 , 19 60 , to Feb. 15 , 19 60 that I last saw the deceased alive on Feb. 14 , 19 60 , and that death occurred at 1 a. m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) LONA CONING, MD. DATE SIGNED 2-18-60			
ACTUAL SIGNATURE Leslie R. Miles Jr. M.D.			
PHYSICIAN'S NAME (Type) LESLIE R. MILES JR. M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/18.60	22c. NAME OF CEMETERY OR CREMATORY Old Coney Cemetery	22d. LOCATION (City, town, or county) (State) Lonaconing, Md.
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn		ADDRESS Lonaconing, Md.	
24a. REC'D BY REGISTRAR DATE FEB 19 '60		24b. REGISTRAR'S SIGNATURE Arthur E. Hines	

TO HOSPITAL ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1431 CERTIFICATE OF DEATH

Reg. Dist. No.

01377

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>		c. LENGTH OF STAY IN 1b <u>I wk.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Miner's Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Edgar</u> Middle <u>Woodrow</u> Last <u>Donius</u>		4. DATE OF DEATH Month <u>2</u> Day <u>15</u> Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 2nd., 1918</u>
9. AGE (In years last birthday) <u>42</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Brick</u>	
11. BIRTHPLACE (State or foreign country) <u>Zihlman</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>George Donius</u>		14. MOTHER'S MAIDEN NAME <u>Rose Porter</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>217-10-5886</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pancreatitis</u> <u>587.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>4 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
18. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20b. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20d. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb 2</u> , 19 <u>60</u> , to <u>Feb 15</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Feb 14</u> , 19 <u>60</u> , and that death occurred at <u>7:25 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W O McLane</u> M.D.		ADDRESS (Street, city or town, state) <u>Frostburg Md</u> DATE SIGNED <u>2-15-60</u>	
PHYSICIAN'S NAME (Type) <u>W O McLane MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-17-1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Finkel Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Frostburg Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Paul H. Mattingly</u>		24a. REC'D BY REGISTRAR <u>FEB 25 60</u>	
24b. REGISTRAR'S SIGNATURE <u>Carroll S. Pratt</u>			

1931 CERTIFICATE OF DEATH

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

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CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 62 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last CHRISTINE DOOLAN		4. DATE OF DEATH Month Day Year FEBRUARY 25 1960	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1887 AUGUST 6, 1887
9. AGE (In years lost birthday) 72 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY PEKIN, MD.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN DARNLEY		14. MOTHER'S MAIDEN NAME KATHERINE MACKEY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT MEMORIAL HOSPITAL		Address CUMBERLAND, MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute left ventricular failure 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Auricular fibrillation DUE TO (c) Myocardial fibrosis & coronary arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) left bundle branch block, uremia Incomplete wight hemiplegia, cerebral embolus, left ventricle hypertrophy,		INTERVAL BETWEEN ONSET AND DEATH sudden ??	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12/25/1959 to 2/25/1960 , that (I) (we) last saw the deceased alive on 2/25/1960 , and that death occurred at 8:16 PM , from the causes and on the date stated above.			
22a. SIGNATURE Samuel M. Jacobson M.D.		22b. DATE SIGNED 2/27/60	
22c. PHYSICIAN'S NAME (Type) Samuel M. Jacobson, M. D.		22d. ADDRESS 50 Pershing St. Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 29, 1960	
23c. NAME OF CEMETERY OR CREMATORY St. Marys Cemetery		23d. LOCATION (City, town, or county) (State) Lonaconing, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn		25a. REC'D BY REGISTRAR DATE MAR 1 '60	
ADDRESS Lonaconing, Maryland		25b. REGISTRAR'S SIGNATURE Arthur S. K...	

C. J. A. J. S.

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VR A1S (4)
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1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 6 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL WARWICK & MEMORIAL AVENUES		d. STREET ADDRESS R.F.D. #4,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First STEPHEN		Middle R.		Last EDWARDS	
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF DEATH Month FEBRUARY		9. DAY 2,		10. YEAR 19 60.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Engineer		11b. KIND OF BUSINESS OR INDUSTRY B. & O. Railroad		11. BIRTHPLACE (State or foreign country) PAW PAW, W. VA.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME ROBERT EDWARDS		14. MOTHER'S MAIDEN NAME MARGARET GODDARD	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address MEMORIAL HOSPITAL - CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) Cerebral Vascular Accident Shunt of carotid artery to cerebral vessels.		INTERVAL BETWEEN ONSET AND DEATH 15 mins			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pneumonia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 133 VIRGINIA AVE., CUMBERLAND, MD.	
20f. (City or town) CUMBERLAND		(County) ALLEGANY		(State) MARYLAND	
21. I certify that (I) (this hospital) attended the deceased from Jan 19 60 to Feb 2 19 60 that (I) (we) last saw the deceased alive on Feb 2 19 60 and that death occurred at 8:15 AM from the causes and on the date stated above.		22a. SIGNATURE DR. G. O. HIMMELWRIGHT		22b. DATE SIGNED 2/4/60	
22c. PHYSICIAN'S NAME (Type) DR. G. O. HIMMELWRIGHT		22d. ADDRESS 133 VIRGINIA AVE., CUMBERLAND, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/5/60		23c. NAME OF CEMETERY OR CREMATORY Hilcrest Burial Park	
23d. LOCATION (City, town, or county) Cumberland, Maryland		(State) MARYLAND			
24. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		25a. REGISTRY REGISTRAR DATE FEB 10 1960		25b. REGISTRAR'S SIGNATURE Arthur S. Hafer	

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MINISTRE DU DÉPARTEMENT DE LA SANTÉ
MINISTRY OF HEALTH
CERTIFICATE OF DEATH

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DR. R. A. J. JR.

DR. R. A. J. JR.

DR. R. A. J. JR.

ANTHONY DOMANO

ROBERT EDWARDS

GENERAL HOSPITAL - CLEVELAND, OH.

DR.

Robert Edwards
1000 West 10th Ave.
Cleveland, Ohio

10-17-18

1000 WEST 10TH AVE., CLEVELAND, OH.

DR. R. A. J. JR.

1000 WEST 10TH AVE., CLEVELAND, OH.

1000 WEST 10TH AVE., CLEVELAND, OH.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

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Reg. No. 10

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01381

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Penn b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyndman	
c. LENGTH OF STAY IN 1b 2 hr.		75X-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Earl Emerick		4. DATE OF DEATH Month Day Year 2 7 1960	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/7/1895
9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Penn		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Will Emerick		14. MOTHER'S MAIDEN NAME Sarah M. Clites	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Sister in Law Mrs. Orrie Emerick		Address Hyndman Penn	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Peritonitis, generalized 540.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Perforated peptic ulcer DUE TO (c) 48 hrs. 48 hrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Benedict Skitarelic M.D.		DATE SIGNED	
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> February 7, 1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 11, 1960	
22c. NAME OF CEMETERY OR CREMATORY Comps Cemetery		22d. LOCATION (City, town, or county) (State) Hyndman, Pa. Somerset Co.	
23. FUNERAL DIRECTOR'S SIGNATURE Harvey H. Zeigler ADDRESS Hyndman, Pa.		24a. REC'D BY REGISTRAR FEB 15 '60 DATE	
		24b. REGISTRAR'S SIGNATURE Arthur S. H.	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE DEPARTMENT OF HEALTH - BALTIMORE 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01881

Page 1 of 1

1893

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF EXAMINER		DATE	
DISEASE		SYMPTOMS		TREATMENT		PROGNOSIS		FINDINGS AT AUTOPSY		REMARKS	
HISTORY		PHYSICAL EXAMINATION		LABORATORY EXAMINATIONS		PATHOLOGICAL FINDINGS		MICROSCOPIC FINDINGS		BACTERIOLOGICAL FINDINGS	
FAMILY HISTORY		SOCIAL HISTORY		HABITS		PREVIOUS ILLNESSES		VACCINATIONS		OTHER FACTORS	
SIGNATURE OF EXAMINER		DATE		SIGNATURE OF WITNESS		DATE		SIGNATURE OF JURY		DATE	

RECEIVED

STATE DEPARTMENT OF HEALTH - BALTIMORE 18

1432 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Savage			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Gilbert Middle C. Emerick Last				4. DATE OF DEATH Month February Day 21 Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 25, 1887		9. AGE (In years last birthday) yrs. 72	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner		10b. KIND OF BUSINESS OR INDUSTRY Mining		11. BIRTHPLACE (State or foreign country) Fairhope, Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Alex Emerick				14. MOTHER'S MAIDEN NAME Jane Kennell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 217-10-1050		17. INFORMANT Mrs. Mary Emerick, Mt. Savage, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH 10 yrs.	
MEDICAL CERTIFICATION							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JUNE , 19 57 , to FEB. 21 , 19 60 , that I last saw the deceased alive on FEB. 21 , 19 60 , and that death occurred at 3:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Martin M. Rothstein M.D. 48 BROADWAY 2/22/60 PHYSICIAN'S NAME (Type) MARTIN M. ROTHSTEIN M.D. FROSTBURG - MD.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 24, 1960		22c. NAME OF CEMETERY OR CREMATORY St. Patrick's Cemetery Mt. Savage, Maryland		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Harvey A. Ziegler ADDRESS Hyndman, Pa.				24a. REC'D BY REGISTRAR DATE FEB 25 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1380 CERTIFICATE OF DEATH

Reg. Dist. No.

01383

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Pa.</u> b. COUNTY <u>Bedford</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>			c. LENGTH OF STAY IN 1b <u>32 days</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart Hospital</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Hyndman Rt. # 1</u>		
			d. STREET ADDRESS <u>75X-3</u>		
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Henry</u> Last <u>Emerick</u>			4. DATE OF DEATH Month <u>Feb</u> Day <u>25</u> Year <u>19 60</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years last birthday) <u>78</u> yrs.
			IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Re tired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Celanese Corp.</u>		11. BIRTHPLACE (State or foreign country) <u>Pa.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>John Emerick</u>			14. MOTHER'S MAIDEN NAME <u>Elizabeth Albright</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]			16. SOCIAL SECURITY NO. <u>215-14-6095</u>		
			INFORMANT <u>Chart</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of the stomach</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <u>Hyndman</u>	(County) <u>Pa.</u>	(State) <u>Pa.</u>
21. I certify that I attended the deceased from <u>1-4</u> , 19 <u>60</u> , to <u>2-25</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>2-25</u> , 19 <u>60</u> , and that death occurred on <u>2-25</u> A.M., from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>L. Brings</u>			ADDRESS (Street, city or town, state) <u>57 Greene Street</u>		
PHYSICIAN'S NAME (Type) <u>Dr. L. Brings</u>			DATE SIGNED <u>Mar 1 1960</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>2/28/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Porter Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Hyndman, Pa.</u>		(State) <u>Pa.</u>		22e. REC'D BY REGISTRAR <u>Harvey H. Leigler</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harvey H. Leigler</u>		ADDRESS <u>Hyndman, Pa.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hana</u>	

MASSACHUSETTS DEPARTMENT OF HEALTH

1380

01883

MASSACHUSETTS DEPARTMENT OF HEALTH

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01384

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> 1381 MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> c. LENGTH OF STAY IN 1b <u>50yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> <u>02</u> d. STREET ADDRESS <u>418 Seymour Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Nora</u> Middle <u>Emerson</u> Last _____ 4. DATE OF DEATH Month <u>Feb.</u> Day <u>25</u> Year <u>1960</u>			5. SEX <u>F</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>April 27, 1885</u> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) <u>74</u> yrs. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY _____ 11. BIRTHPLACE (State or foreign country) <u>Penna.</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				
13. FATHER'S NAME <u>Henry Porter</u>		14. MOTHER'S MAIDEN NAME <u>Mary Smith</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mr. Michael Perry 418 Seymour St.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION, RIGHT</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>CORONARY THROMBOSIS</u> (c) <u>stoking the underlying cause lost.</u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Emaciation, marked</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____			
20f. (City or town) _____ (County) _____ (State) _____		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>Benedict Skitarellic</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <u>BENEDICT SKITARELIC, M.D.</u> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>FEB. 25, 1960</u>		DATE SIGNED _____					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-27-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>County Cemetery</u>			
22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>		23. FURNERAL DIRECTOR'S SIGNATURE ADDRESS <u>James F. Scarpelli Cumberland, Md.</u>					
24a. REC'D BY REGISTRAR DATE <u>FEB 29 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

185

25

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

01385

1433 CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN lb 10 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miner's Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Anna Middle Fannon Last Fannon		4. DATE OF DEATH Month February Day 21st Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 15th, 1880
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY own housework	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Patrick H. Farrell		14. MOTHER'S MAIDEN NAME Sarah Conlin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Daniel Williams, Mt. Savage, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive arteriosclerotic Heart Disease DUE TO 10 yrs? Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from DEC 19 59 to 2/21 1960 that (I) (we) last saw the deceased alive on 2/21 1960 and that death occurred at 11 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Martin M. Rothstein M.D.		22b. DATE SIGNED _____	
22c. PHYSICIAN'S NAME (Type) Martin M. Rothstein		22d. ADDRESS 48 Broadway, Frostburg, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-25-60	
23c. NAME OF CEMETERY OR CREMATORY St. Patrick's Cemetery		23d. LOCATION (City, town, or county) (State) Mt. Savage, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Durst, Frostburg, Md.		25a. REC'D BY REGISTRAR DATE FEB 25 '60	
25b. REGISTRAR'S SIGNATURE Christina S. Kraw			

1434 CERTIFICATE OF DEATH

01386

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital		X d. STREET ADDRESS Washington, ST.	
3. NAME OF DECEASED (Type or print) JANE T. FAZENBAKER		4. DATE OF DEATH 2/1/1960 19	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED: <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/23/1901
9. AGE (In years last birthday) 58 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Lonaconing, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George McCormick		14. MOTHER'S MAIDEN NAME Lora Fazenbaker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Clarence Fazenbaker		Address Lonaconing, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocarditis, Rheumatic fever 415X DUE TO (b) Reactivation of rheumatic fever Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Virus pneumonia INTERVAL BETWEEN ONSET AND DEATH (Husband) 3 days			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/2/60 to 2/2/60 , that I last saw the deceased alive on 2/2/60 , and that death occurred at 11:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 271 Main St., Lonaconing DATE SIGNED George Vash ACTUAL SIGNATURE George Vash PHYSICIAN'S NAME (Type) George Vash			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/4/1960	
22c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery		22d. LOCATION (City, town, or county) (State) Lonaconing, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE GEORGE EICHHORN,		24a. REC'D BY REGISTRAR FEB 5 '60	
ADDRESS LONA CONING, MD.		24b. REGISTRAR'S SIGNATURE Charles E. Howard	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

[illegible]

1382 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - FROSTBURG		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x Rural - FROSTBURG, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Memorial Hospital - P.O.A.		d. STREET ADDRESS Rt #1 Box 2A Frostburg, Md.	
3. NAME OF DECEASED (Type or print) First Kenneth Middle Lee Last FESTERMAN		4. DATE OF DEATH Month February Day 8 Year 1960	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 31, 1953
9. AGE (In years last birthday) 6 yrs.		IF UNDER 1 YEAR Months 6 Days 0 Hours 0 Min. 0	IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA.		13. FATHER'S NAME Kenneth Gene FESTERMAN	
14. MOTHER'S MAIDEN NAME Margaretta C. DREES		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mr. Kenneth G. FESTERMAN Rt #1 Box 2A Frostburg Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 351X Malnutrition DUE TO (b) Cerebral Palsy (severe) DUE TO (c) 6 yr. 6 yr.			INTERVAL BETWEEN ONSET AND DEATH 6 yr.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) "Flu" - 8 days - Recovering			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from March 10, 1958 , to Feb. 8, 1960 , that I last saw the deceased alive on February 8, 1960 , and that death occurred at 5:00 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Ralph A. Reiter M.D.		ADDRESS (Street, city or town, state) 112 Bedford St. Cumberland Md	
PHYSICIAN'S NAME (Type) Ralph A. REITER, M.D.		DATE SIGNED 2/8/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2-11-60	22c. NAME OF CEMETERY OR CREMATORY Finsel Cemetery	22d. LOCATION (City, town, or county) (State) Finsel, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Durst, Frostburg, Md.		24a. RECEIVED BY REGISTRAR FEB 12 1960 24b. REGISTRAR'S SIGNATURE William S. Kline	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

01887

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of birth		5. Place of birth		6. Date of death		7. Place of death		8. Cause of death		9. Manner of death		10. Signature of physician		11. Signature of registrar		12. Date of registration	
JAMES H. JONES		Male		35		1915		Baltimore, Md.		1950		Baltimore, Md.		Heart Disease		Natural		J. H. Jones		J. H. Jones		1950	
13. Name of informant		14. Relationship		15. Address		16. City		17. State		18. Zip		19. Date of completion		20. Signature of informant		21. Signature of registrar		22. Date of registration		23. Date of completion		24. Signature of registrar	
J. H. Jones		Son		1234 Main St.		Baltimore		Md.		21201		1950		J. H. Jones		J. H. Jones		1950		1950		J. H. Jones	

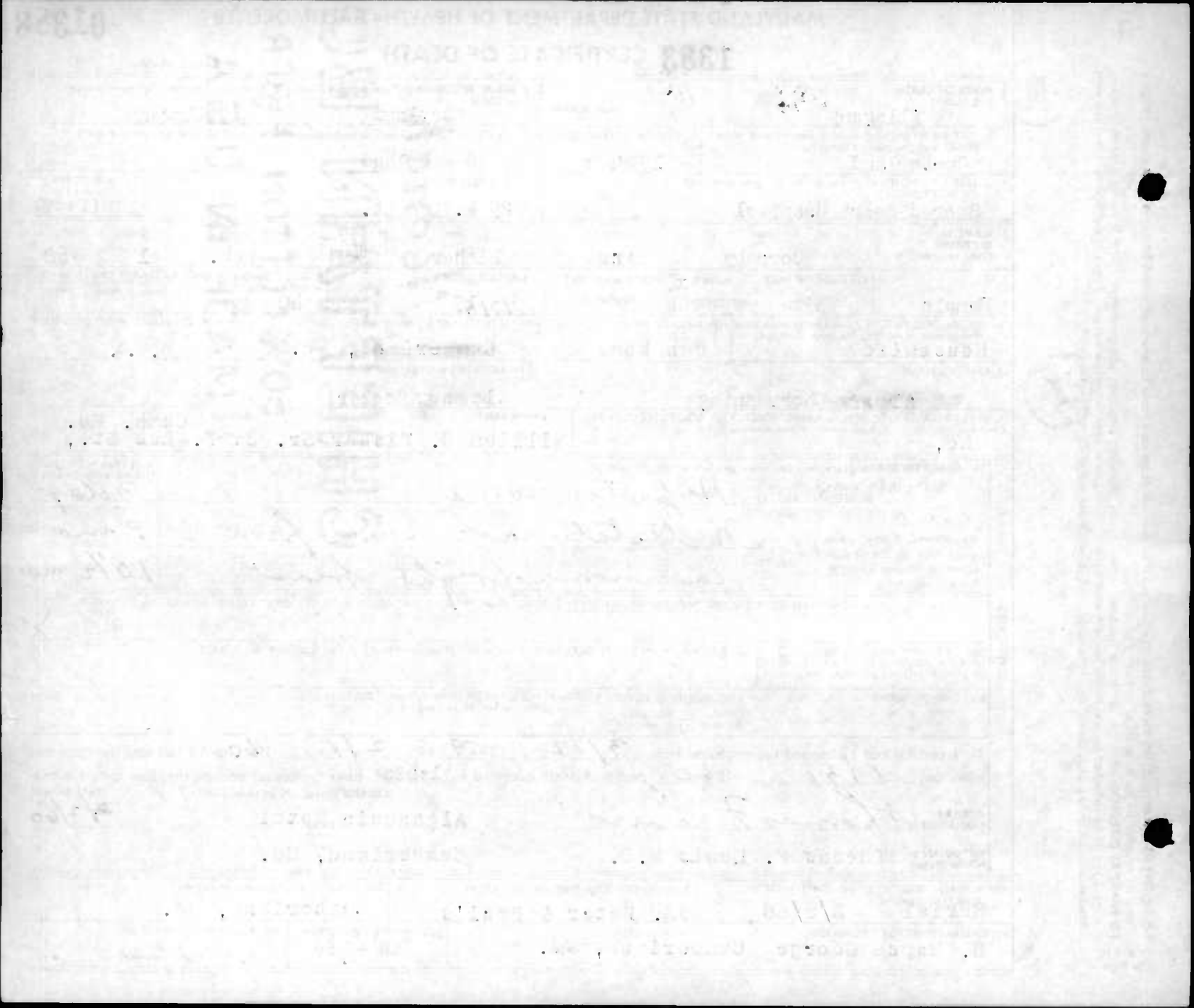
1383 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	c. LENGTH OF STAY IN 1b 13 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Dorothy Middle Ann Last Fisher		4. DATE OF DEATH Month Feb. Day 1 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/5/19
9. AGE (In years lost birthday) 40 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	11. BIRTHPLACE (State or foreign country) Cumberland, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Alonzo Chorpennig		14. MOTHER'S MAIDEN NAME Eleanor Decker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No,		16. SOCIAL SECURITY NO. INFORMANT William G. Fisher Sr. Address Cumb. Md. 29 N. Lee St.,	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic coma DUE TO 170x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastatic carcinoma from DUE TO carcinoma of right breast (c) 10 1/2 mo.			INTERVAL BETWEEN ONSET AND DEATH 3 days 2 mo. 10 1/2 mo.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 3/12 , 19 59 , to 2/1 , 19 60 , that I last saw the deceased alive on 1/31 , 19 60 , and that death occurred at 1:42a , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Algonquin Hotel DATE SIGNED 2/2/60			
ACTUAL SIGNATURE Thomas F. Lewis		M.D. Algonquin Hotel	
PHYSICIAN'S NAME (Type) Thomas F. Lewis M.D.		Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/3/60	22c. NAME OF CEMETERY OR CREMATORY SS. Peter & Paul's	22d. LOCATION (City, town, or county) (State) Cumberland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR DATE FEB 4 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1384

CERTIFICATE OF DEATH

01389

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 15 DAYS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL, MEMORIAL & WARWICK AVES.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LONA CONING d. STREET ADDRESS WATERCLIFFE STREET e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle R. Last FOOTE		4. DATE OF DEATH Month FEBRUARY Day 16 Year 1960	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 12, 1892
9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) COAL MINER		10b. KIND OF BUSINESS OR INDUSTRY LONA CONING, MARYLAND	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME FELIX FOOTE		14. MOTHER'S MAIDEN NAME SARAH WRIGHT	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 214-01-3561	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) pneumonia 523.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) secondary to silicosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 weeks			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb 4, 1960 to Feb 16, 1960 , that (I) (we) last saw the deceased alive on Feb 16, 1960 , and that death occurred at 3:40 AM the causes and on the date stated above.			
22a. SIGNATURE David H. Miller M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) DR. D. H. MILLER.		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/19/60	
23c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery		23d. LOCATION (City, town, or county) (State) Lonaconing, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn		25a. REC'D BY REGISTRAR FEB 19 1960	
ADDRESS Lonaconing, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

01389

1384

ALLEGANY

WYAND

LOWANOWING

15 DAYS

15 DAYS

WATERGATE STREET

WATERGATE STREET

TELEPHONE

ROUTE

15

15

WATERGATE STREET

15

WHITE

WHITE

WATERGATE STREET

WATERGATE STREET

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WATERGATE STREET

WATERGATE STREET

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

01390

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 21 DAYS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND d. STREET ADDRESS 109 PARK ST. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First VIOLA Middle LOUISE Last FRALEY		4. DATE OF DEATH Month FEB. Day 21 Year 19 60									
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>							
8. DATE OF BIRTH 5/10/1886		9. AGE (In years last birthday) 73 yrs. <table border="1" style="display: inline-table; vertical-align: middle;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.									
Months	Days	Hours	Min.								
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) MARYLAND, Cumberland							
12. CITIZEN OF WHAT COUNTRY? U. S. A.											
13. FATHER'S NAME JOHN GERDEMAN (DECEASED)			14. MOTHER'S MAIDEN NAME Almira Long								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Cumb. Md. Walter A. Fraley 306 Cumberland, St.,							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="2" style="text-align: center; vertical-align: top;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Contusion of brain 900.0 DUE TO Skull fracture </td> <td style="text-align: center; vertical-align: top;"> INTERVAL BETWEEN ONSET AND DEATH 22 days </td> </tr> <tr> <td colspan="2" style="text-align: center; vertical-align: top;"> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO </td> <td style="text-align: center; vertical-align: top;"> 22 days </td> </tr> </table>						PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Contusion of brain 900.0 DUE TO Skull fracture		INTERVAL BETWEEN ONSET AND DEATH 22 days	Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO		22 days
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Contusion of brain 900.0 DUE TO Skull fracture		INTERVAL BETWEEN ONSET AND DEATH 22 days									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO		22 days									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell down five steps striking head on concrete									
20c. TIME OF INJURY Month, Day, Year 2:30 p.m. Jan. 30 1960		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home 20f. (City or town) (County) (State) Cumberland, Alleg. Md.							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/>, Accident <input checked="" type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.											
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED February 21, 1960							
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/24/60		22c. NAME OF CEMETERY OR CREMATORY SS. Peter & Paul's							
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George		ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR DATE FEB 23 '60							
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>											

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

01391

1386 CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 3 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND			
d. NAME OF HOSPITAL (If not in hospital, give place of death) MEMORIAL HOSPITAL AVE.				d. STREET ADDRESS 18 AVENUE K. POTOMAC PARK		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MAUDE Middle CARRIE Last GORDON				4. DATE OF DEATH Month FEBRUARY Day 18 Year 60			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 7, 1886		9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME JOHN NORRIS				14. MOTHER'S MAIDEN NAME BELLE L. RUBY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO 493X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Congestive Heart Failure Arteriosclerotic Cardio-Vasc							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Dissect					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2/10 19 60 , to 2/18 19 60 , that (I) (we) last saw the deceased alive on 2/18 19 60 , and that death occurred at 6:57A , from the causes and on the date stated above.							
22a. SIGNATURE DR. LEO H. LEY				22b. DATE SIGNED 2/19/60		22c. PHYSICIAN'S NAME (Type) DR. LEO H. LEY	
22d. ADDRESS Cumberland Md.				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 20, 1960		23c. NAME OF CEMETERY OR CREMATORY Fairview Christian Cem. Nr. Artemas, Penna.		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George				24a. REC'D BY REGISTRAR DATE FEB 23 '60		24b. REGISTRAR'S SIGNATURE Cuthbert L. Kraus	

01810

1938

NEURORHINOLOGY

NEURORHINOLOGY

NEURORHINOLOGY

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NEURORHINOLOGY

NEURORHINOLOGY

DR. FRED H. JENKINS

NEURORHINOLOGY

NEURORHINOLOGY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01392

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany 1387 MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,			c. LENGTH OF STAY IN 1b 02 Cumberland,				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Y.M.C.A. 205 Balto. Ave.,				e. STREET ADDRESS Y.M.C.A. 205 Balto. Ave.,			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First George Middle C. Last Gore		4. DATE OF DEATH Month Feb. Day 5, Year 19 60					
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 2, 1882		9. AGE (In years last birthday) 78 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rest. Prop.		10b. KIND OF BUSINESS OR INDUSTRY Restaurant		11. BIRTHPLACE (State or foreign country) Cameron Co. Penna.	12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME George W. Gore			14. MOTHER'S MAIDEN NAME Eliza Jordan				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. None		17. INFORMANT Dr. Bernard Hetrick Address Slippery Rock, Penna.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Coronary sclerosis Conditions, if any, which gave rise to immediate cause (b) _____ (c) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH Sudden ?							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>		EXAMINER'S NAME (Type) Benedict Skitarelic M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DATE SIGNED 2/5/60							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/8/60		22c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park			
22d. LOCATION (City, town, or county) Cumberland, Md.		22e. (State)					
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George ADDRESS Cumberland, Md.				24a. REC'D BY REGISTRAR DATE FEB 8 '60			
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

01303

STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. RACE White	
5. DATE OF DEATH April 4, 1968		6. TIME OF DEATH 2:01 PM		7. PLACE OF DEATH Room 306, LBJ Library, Washington, D.C.		8. CITY Washington, D.C.	
9. COUNTY District of Columbia		10. STATE District of Columbia		11. ZIP CODE 20540		12. MARRIAGE Single	
13. OCCUPATION Attorney		14. EDUCATION Bachelor's Degree		15. RELIGION Methodist		16. SOCIAL SECURITY NUMBER [REDACTED]	
17. MARITAL STATUS Single		18. DATE OF BIRTH [REDACTED]		19. PLACE OF BIRTH [REDACTED]		20. US CITIZENSHIP Naturalized	
21. PREVIOUS MARRIAGES None		22. DATE OF LAST MARRIAGE None		23. NAME OF SPOUSE None		24. NAME OF CHILDREN None	
25. PRESENT ADDRESS [REDACTED]		26. HOME PHONE [REDACTED]		27. BUSINESS PHONE [REDACTED]		28. MAILING ADDRESS [REDACTED]	
29. EMPLOYER [REDACTED]		30. EMPLOYMENT STATUS Full Time		31. DATE OF EMPLOYMENT [REDACTED]		32. TYPE OF EMPLOYMENT Salaried	
33. REASON FOR DEATH Suicide		34. CAUSE OF DEATH Self-inflicted gunshot wound		35. MANNER OF DEATH Homicide		36. TOXICOLOGY None	
37. ALCOHOL None		38. DRUGS None		39. OTHER SUBSTANCES None		40. MEDICAL HISTORY None	
41. PREVIOUS ILLNESSES None		42. SURGICAL HISTORY None		43. ALLERGIES None		44. MEDICATIONS None	
45. PHYSICIAN [REDACTED]		46. HOSPITAL [REDACTED]		47. NURSE [REDACTED]		48. PATHOLOGIST [REDACTED]	
49. SIGNATURE OF EXAMINER [REDACTED]		50. DATE OF EXAMINATION April 4, 1968		51. SIGNATURE OF WITNESS [REDACTED]		52. DATE OF WITNESS April 4, 1968	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1388 CERTIFICATE OF DEATH

01393

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 5 DAYS	
d. NAME OF HOSPITAL (If in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LAVINA Middle GROSS Last GROSS		4. DATE OF DEATH Month FEBRUARY Day 22 Year 1960	
5. SEX FEMALE,	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCTOBER 24, 1873
9. AGE (In years lost birthday) 86 yrs.		10. IF UNDER 1 YEAR Months 6 Days 22 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) MARYLAND Oldtown		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN TWIGG		14. MOTHER'S MAIDEN NAME RACHAEL LUTMAN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac decompensation 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Generalized arteriosclerosis DUE TO (c) Carcinoma liver PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 5 days ? 1 yr			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2/11 1960 to 2/22 1960 , that (I) (we) last saw the deceased alive on 2/22 1960 , and that death occurred 9:27 AM from the causes and on the date stated above.			
22a. SIGNATURE [Signature]		22b. DATE SIGNED 2/24/60	
22c. PHYSICIAN'S NAME (Type) DR. SIMONS		22d. ADDRESS Allegany Hotel Cumberland, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/24/60	
23c. NAME OF CEMETERY OR CREMATORY Oldtown Cemetery		23d. LOCATION (City, town, or county) (State) Oldtown, Alleg., Md	
24. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		25a. REC'D BY REGISTRAR DATE FEB 26 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

1932
CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH
BOSTON, MASS.

01303

Name of Deceased		Age		Sex		Race		Color	
ALLEGRA		28		F		WHITE		WHITE	
Place of Birth		Date of Birth		Date of Death		Time of Death		Place of Death	
CHICAGO, ILL.		JAN 10 1904		JAN 10 1932		10:30 AM		HOSPITAL, CHICAGO, ILL.	
Cause of Death		Manner of Death		Occupation		Education		Religion	
HEART DISEASE		NATURAL		Nurse		High School		Catholic	
Signature of Physician		Signature of Registrar		Signature of Informant		Signature of Coroner		Signature of Burial Officer	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
Date of Report		Date of Burial		Date of Interment		Date of Cremation		Date of Disposition	
JAN 12 1932		JAN 12 1932		JAN 12 1932		JAN 12 1932		JAN 12 1932	

1389 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. LENGTH OF STAY IN 1b <u>14 hrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Laura</u> Middle <u>Lee</u> Last <u>Himmeler</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>18</u> Year <u>19 60</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-7-1889</u>	
9. AGE (In years lost birthday) <u>70 yrs.</u>		10. USUAL OCCUPATION (Give kind of work done, during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frederick Himmeler</u>				14. MOTHER'S MAIDEN NAME <u>Laura L. Bowers</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>		INFORMANT <u>Sacred Heart Hosp. Cumb. Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>434.2 Acute Bulimic Edema</u> DUE TO (b) <u>myocardial Failure</u> DUE TO (c) <u>3 days</u>						INTERVAL BETWEEN ONSET AND DEATH <u>14 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>RT. middle and lower lobe pneumonia</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>2-17</u> , 19 <u>60</u> , to <u>2-18</u> , 19 <u>60</u> that I last saw the deceased alive on <u>2-18</u> , 19 <u>60</u> , and that death occurred at <u>6:47 PM</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>441 N. Centre St</u> DATE SIGNED <u>2-18-60</u>							
ACTUAL SIGNATURE <u>William P. James</u>				PHYSICIAN'S NAME (Type) <u>William P. James</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>2/22/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Lukes Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein Inc.</u>				ADDRESS <u>Cumb. Md.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 24 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hunt</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

0030

CERTIFICATE OF DEATH

1388

NOT VALID



1390 CERTIFICATE OF DEATH

01395

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALL EGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 6 HRS.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART HOSPITAL				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X CUMBERLAND			
f. STREET ADDRESS RT. #1 BOX 169 Cresap Park				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First HAROLD Middle DeLOS Last HOSIER				4. DATE OF DEATH Month FEB. Day 21 Year 1960			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/8/1900	
9. AGE (In years last birthday) 59 yrs.		10. IF UNDER 1 YEAR Months 59 Days 59 Hours 59 Min.		11. IF UNDER 24 HRS. Months 59 Days 59 Hours 59 Min.		12. IF UNDER 24 HRS. Months 59 Days 59 Hours 59 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CRANE OPERATOR				10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) PENNA.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME WATSON HOSIER (DECEASED)				14. MOTHER'S MAIDEN NAME LAURA PHELPS (DECEASED)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 214-05-7569			
17. INFORMANT Mrs. Harold Hosier				Address Rt 1 Cumberland, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma, Pancreas DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 7/20 , 19 60 , to 7/20 , 19 60 , that I last saw the deceased alive on 7/20 , 19 60 , and that death occurred at 12:00 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 456 N. Centre St., Cumberland, Md. DATE SIGNED 7/21/60							
ACTUAL SIGNATURE Leo H. Ley, Jr. M.D.				PHYSICIAN'S NAME (Type) Leo H. Ley, Jr., M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Feb. 24, 1960			
22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park				22d. LOCATION (City, town, or county) (State) Cumberland, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George,				ADDRESS Cumberland, Md.			
24a. REC'D BY REGISTRAR DATE FEB 25 '60				24b. REGISTRAR'S SIGNATURE Arthur S. Harris			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 1 of 1.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1380 CHURCH OF TRUTH

1380 CHURCH OF TRUTH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

01396

1446

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Barton		c. LENGTH OF STAY IN 1b 69 Yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Barton	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			d. STREET ADDRESS		
3. NAME OF DECEASED (Type or print) Charles First Howell Middle Lost			4. DATE OF DEATH Feb. Month 27 Day 1960 Year		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 17, 1890		9. AGE (In years last birthday) 69 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner		10b. KIND OF BUSINESS OR INDUSTRY Coal Mine		11. BIRTHPLACE (State or foreign country) Barton, Md.	
13. FATHER'S NAME Charles Howell			14. MOTHER'S MAIDEN NAME Mary Ann Egan		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 181-10-8086		17. INFORMANT Joseph Howell-Barton, Md. Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Sclerosis & Thrombosis (c) Arterio Sclerosis</p> </div> <div style="width: 50%;"> <p>INTERVAL BETWEEN ONSET AND DEATH Sudden</p> </div> </div>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE W O McLane		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Feb. 27, 1960 DATE SIGNED			
EXAMINER'S NAME (Type) W. O. McLane, M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/1/60		22c. NAME OF CEMETERY OR CREMATORY St. Gabriel's Cem	
23. FUNERAL DIRECTOR'S SIGNATURE E. L. Boal		ADDRESS Westernport, Md.		24a. REC'D BY REGISTRAR MAR 1 '60 24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1391 CERTIFICATE OF DEATH

Reg. Dist. No.

01397

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 2/17/60	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Annie Middle Margaret Last Hughes		4. DATE OF DEATH Month February Day 20 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/26/1868
9. AGE (In years last birthday) 91 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	11. IF UNDER 24 HRS. Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Wolfgang Smith		14. MOTHER'S MAIDEN NAME Magdalena Weisenmiller	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT P. O. Box 599, Allegany County Infirmary Records		Address Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic myocardial degeneration 592X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral arteriosclerosis DUE TO (c) Chronic nephritis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senile deterioration			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/17/60 , 19____, to 2/20/60 , 19____, that I last saw the deceased alive on 2/19/60 , 19____, and that death occurred at 2:45 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE James E. McLean M.D.		ADDRESS (Street, city or town, state) 49 Greeno St. Cumberland, Md.	
PHYSICIAN'S NAME (Type) Dr. James E. McLean		DATE SIGNED 2/20/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/22/60	
22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR FEB 23 '60	
		24b. REGISTRAR'S SIGNATURE Arthur L. Kline	

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21. *Veronica* *sp.*

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doi:10.1017/S0007122612000054

2000

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01398

1392

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 45 MINUTES			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JOHN Middle L Last HULL				4. DATE OF DEATH Month FEBRUARY Day 22 Year 1960			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH APRIL 15, 1878	
9. AGE (In years lost birthday) 81 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Engineer				10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) WASHINGTON CO. MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Otho #OTHA HULL				14. MOTHER'S MAIDEN NAME Hancock Md. #MARTHA #HOUT# Anna Houck			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 705-07-6648		17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Ventricular Fibrillation 422.1 DUE TO Chronic Myocardial Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Arteriosclerosis (c) Arteriosclerosis				INTERVAL BETWEEN ONSET AND DEATH 30 minutes			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2/17/59 19 to 2/22/60 19, that (I) (we) last saw the deceased alive on 2/22/60 19, and that death occurred at 12:30 PM from the causes and on the date stated above.							
22a. SIGNATURE R. J. WILLIAMS				22b. DATE SIGNED 2/24/60			
22c. PHYSICIAN'S NAME (Type) R. J. WILLIAMS				22d. ADDRESS Cumberland Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-25-60		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli ADDRESS Cumberland, Md.				25a. REC'D BY REGISTRAR FEB 26 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RECORDS - BALTIMORE, MARYLAND

01308

NAME: [REDACTED] SEX: [REDACTED] RACE: [REDACTED]
DATE OF BIRTH: [REDACTED] PLACE OF BIRTH: [REDACTED]
RESIDENCE: [REDACTED]
OCCUPATION: [REDACTED]
CAUSE OF DEATH: [REDACTED]
MANNER OF DEATH: [REDACTED]
DATE OF DEATH: [REDACTED] PLACE OF DEATH: [REDACTED]
SIGNATURE OF PHYSICIAN: [REDACTED]
SIGNATURE OF REGISTRAR: [REDACTED]

01399

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

1. PLACE OF DEATH a. COUNTY		1435		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
Allegany		MARYLAND		a. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN TB		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
XXXXXXX Frostburg		Lifetime		22 Frostburg	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM?	
Miners Hospital				99 Park Avenue YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First		Middle	
Leonard		C.		Last	
4. DATE OF DEATH		Month		Day	
2		19		1960	
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
Male		Black		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR	
4-4-1899 (1899)		60 yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Laborer		City of Frostburg		Frostburg, Md	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
U. S. A.		James Jackson		Ella Boyer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No		220-10-2157		Mrs. Zellers, Minors Hospital, Frostburg	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 916.0 DUE TO Cardio Vascular Disease		3 mo			
(b) Toxemia from 2nd Degree					
(c) Burns of Rt Chest & Rt Arm					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		Feel asleep smoking in bed - Burns of Rt Arm & Chest	
20c. TIME OF INJURY Month, Day, Year		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
9:00 p.m. Nov 22 1959		While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		Home Frostburg Allegany Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from:		Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
W O - McLane		M.D.		Feb 19 1960	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
W O McLane M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY	
Burial		Feb 22, 1960		Frostburg Mem. Park Frostburg, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
Hafer Funeral Home		DATE FEB 25 '60		C. L. H. H. H.	
25 East Main					
Frostburg, Md.					

01329

MARYLAND DEPARTMENT OF HEALTH-BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

1483

NAME OF DECEASED		AGE		SEX		RACE		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		RESIDENCE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF EXAMINER		DATE	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1393 CERTIFICATE OF DEATH

01400

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 2 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Marvin Middle E. Last Johnson		4. DATE OF DEATH Month Feb. Day 7 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/20/1893
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months 66 Days 66 Hours 66 Min. 66	IF UNDER 24 HRS. Months 66 Days 66 Hours 66 Min. 66
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret-Off-bearer		10b. KIND OF BUSINESS OR INDUSTRY Mt.Sav.Refract.	
11. BIRTHPLACE (State or foreign country) Great Cacapon, W.Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Lee Johnson		14. MOTHER'S MAIDEN NAME Ann Johnson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 1		16. SOCIAL SECURITY NO. 217-03-1112	
17. INFORMANT Memorial Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Degeneration 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Congestive Heart Failure Pulmonary Cysts 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/26 , 19 60 , to 7/7 , 19 60 , that I last saw the deceased alive on 7/7 , 19 60 , and that death occurred at 3:50PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 456 N. Centre St. DATE SIGNED 7/8/60 ACTUAL SIGNATURE Leo D. Ley M.D. PHYSICIAN'S NAME (Type) Dr. Leo Ley Cumberland Ind			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-9-60	
22c. NAME OF CEMETERY OR CREMATORY M.E.Cemetery		22d. LOCATION (City, town, or county) (State) Mt. Savage, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Durst, Frostburg, Md.		24a. REC'D BY REGISTRAR FEB 12 '60	
24b. REGISTRAR'S SIGNATURE Arthur L. Hines			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TAIN BOND

1983 CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

01111

1. NAME OF DECEASED JAMES T. BIRD, JR.		2. DATE OF DEATH 10/10/83	
3. PLACE OF DEATH BALTIMORE, MARYLAND		4. CAUSE OF DEATH HEART DISEASE	
5. MANNER OF DEATH NATURAL		6. AGENT OF DEATH CORONER	
7. SIGNATURE OF DECEASED (None)		8. SIGNATURE OF WITNESSES (None)	
9. SIGNATURE OF DECEASED'S NEXT OF KIN (None)		10. SIGNATURE OF DECEASED'S PHYSICIAN (None)	
11. SIGNATURE OF DECEASED'S MINISTER OF RELIGION (None)		12. SIGNATURE OF DECEASED'S CHURCH (None)	
13. SIGNATURE OF DECEASED'S EMPLOYER (None)		14. SIGNATURE OF DECEASED'S SCHOOL (None)	
15. SIGNATURE OF DECEASED'S SOCIAL SECURITY OFFICIAL (None)		16. SIGNATURE OF DECEASED'S INSURANCE AGENT (None)	
17. SIGNATURE OF DECEASED'S ATTORNEY (None)		18. SIGNATURE OF DECEASED'S JUDGE (None)	
19. SIGNATURE OF DECEASED'S CLERK (None)		20. SIGNATURE OF DECEASED'S NOTARY (None)	
21. SIGNATURE OF DECEASED'S OTHER OFFICIAL (None)		22. SIGNATURE OF DECEASED'S OTHER OFFICIAL (None)	
23. SIGNATURE OF DECEASED'S OTHER OFFICIAL (None)		24. SIGNATURE OF DECEASED'S OTHER OFFICIAL (None)	
25. SIGNATURE OF DECEASED'S OTHER OFFICIAL (None)		26. SIGNATURE OF DECEASED'S OTHER OFFICIAL (None)	
27. SIGNATURE OF DECEASED'S OTHER OFFICIAL (None)		28. SIGNATURE OF DECEASED'S OTHER OFFICIAL (None)	
29. SIGNATURE OF DECEASED'S OTHER OFFICIAL (None)		30. SIGNATURE OF DECEASED'S OTHER OFFICIAL (None)	
31. SIGNATURE OF DECEASED'S OTHER OFFICIAL (None)		32. SIGNATURE OF DECEASED'S OTHER OFFICIAL (None)	
33. SIGNATURE OF DECEASED'S OTHER OFFICIAL (None)		34. SIGNATURE OF DECEASED'S OTHER OFFICIAL (None)	
35. SIGNATURE OF DECEASED'S OTHER OFFICIAL (None)		36. SIGNATURE OF DECEASED'S OTHER OFFICIAL (None)	
37. SIGNATURE OF DECEASED'S OTHER OFFICIAL (None)		38. SIGNATURE OF DECEASED'S OTHER OFFICIAL (None)	
39. SIGNATURE OF DECEASED'S OTHER OFFICIAL (None)		40. SIGNATURE OF DECEASED'S OTHER OFFICIAL (None)	
41. SIGNATURE OF DECEASED'S OTHER OFFICIAL (None)		42. SIGNATURE OF DECEASED'S OTHER OFFICIAL (None)	
43. SIGNATURE OF DECEASED'S OTHER OFFICIAL (None)		44. SIGNATURE OF DECEASED'S OTHER OFFICIAL (None)	
45. SIGNATURE OF DECEASED'S OTHER OFFICIAL (None)		46. SIGNATURE OF DECEASED'S OTHER OFFICIAL (None)	
47. SIGNATURE OF DECEASED'S OTHER OFFICIAL (None)		48. SIGNATURE OF DECEASED'S OTHER OFFICIAL (None)	
49. SIGNATURE OF DECEASED'S OTHER OFFICIAL (None)		50. SIGNATURE OF DECEASED'S OTHER OFFICIAL (None)	
51. SIGNATURE OF DECEASED'S OTHER OFFICIAL (None)		52. SIGNATURE OF DECEASED'S OTHER OFFICIAL (None)	
53. SIGNATURE OF DECEASED'S OTHER OFFICIAL (None)		54. SIGNATURE OF DECEASED'S OTHER OFFICIAL (None)	
55. SIGNATURE OF DECEASED'S OTHER OFFICIAL (None)		56. SIGNATURE OF DECEASED'S OTHER OFFICIAL (None)	
57. SIGNATURE OF DECEASED'S OTHER OFFICIAL (None)		58. SIGNATURE OF DECEASED'S OTHER OFFICIAL (None)	
59. SIGNATURE OF DECEASED'S OTHER OFFICIAL (None)		60. SIGNATURE OF DECEASED'S OTHER OFFICIAL (None)	
61. SIGNATURE OF DECEASED'S OTHER OFFICIAL (None)		62. SIGNATURE OF DECEASED'S OTHER OFFICIAL (None)	
63. SIGNATURE OF DECEASED'S OTHER OFFICIAL (None)		64. SIGNATURE OF DECEASED'S OTHER OFFICIAL (None)	
65. SIGNATURE OF DECEASED'S OTHER OFFICIAL (None)		66. SIGNATURE OF DECEASED'S OTHER OFFICIAL (None)	
67. SIGNATURE OF DECEASED'S OTHER OFFICIAL (None)		68. SIGNATURE OF DECEASED'S OTHER OFFICIAL (None)	
69. SIGNATURE OF DECEASED'S OTHER OFFICIAL (None)		70. SIGNATURE OF DECEASED'S OTHER OFFICIAL (None)	
71. SIGNATURE OF DECEASED'S OTHER OFFICIAL (None)		72. SIGNATURE OF DECEASED'S OTHER OFFICIAL (None)	
73. SIGNATURE OF DECEASED'S OTHER OFFICIAL (None)		74. SIGNATURE OF DECEASED'S OTHER OFFICIAL (None)	
75. SIGNATURE OF DECEASED'S OTHER OFFICIAL (None)		76. SIGNATURE OF DECEASED'S OTHER OFFICIAL (None)	
77. SIGNATURE OF DECEASED'S OTHER OFFICIAL (None)		78. SIGNATURE OF DECEASED'S OTHER OFFICIAL (None)	
79. SIGNATURE OF DECEASED'S OTHER OFFICIAL (None)		80. SIGNATURE OF DECEASED'S OTHER OFFICIAL (None)	
81. SIGNATURE OF DECEASED'S OTHER OFFICIAL (None)		82. SIGNATURE OF DECEASED'S OTHER OFFICIAL (None)	
83. SIGNATURE OF DECEASED'S OTHER OFFICIAL (None)		84. SIGNATURE OF DECEASED'S OTHER OFFICIAL (None)	
85. SIGNATURE OF DECEASED'S OTHER OFFICIAL (None)		86. SIGNATURE OF DECEASED'S OTHER OFFICIAL (None)	
87. SIGNATURE OF DECEASED'S OTHER OFFICIAL (None)		88. SIGNATURE OF DECEASED'S OTHER OFFICIAL (None)	
89. SIGNATURE OF DECEASED'S OTHER OFFICIAL (None)		90. SIGNATURE OF DECEASED'S OTHER OFFICIAL (None)	
91. SIGNATURE OF DECEASED'S OTHER OFFICIAL (None)		92. SIGNATURE OF DECEASED'S OTHER OFFICIAL (None)	
93. SIGNATURE OF DECEASED'S OTHER OFFICIAL (None)		94. SIGNATURE OF DECEASED'S OTHER OFFICIAL (None)	
95. SIGNATURE OF DECEASED'S OTHER OFFICIAL (None)		96. SIGNATURE OF DECEASED'S OTHER OFFICIAL (None)	
97. SIGNATURE OF DECEASED'S OTHER OFFICIAL (None)		98. SIGNATURE OF DECEASED'S OTHER OFFICIAL (None)	
99. SIGNATURE OF DECEASED'S OTHER OFFICIAL (None)		100. SIGNATURE OF DECEASED'S OTHER OFFICIAL (None)	

CERTIFICATE OF DEATH

01402

Reg. Dist. No.

1395

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
d. NAME OF HOSPITAL (If not in hospital, give street address) MEMORIAL HOSPITAL-MEMORIAL & WARWICK AVES.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First PATRICIA Middle M. Last KIRBY		4. DATE OF DEATH Month FEBRUARY Day 15 Year 1960	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 3, 1921
9. AGE (In years last birthday) 38 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) PENNSYLVANIA, PHILA.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ALFRED BENNY		14. MOTHER'S MAIDEN NAME MYRTLE FOLEY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 581.1 DUE TO Coronary lesion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Atherosclerosis chronic (c) Atherosclerosis chronic PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 20 mins			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify, that I attended the deceased from 219 , 19 60 , to 2115 , 19 60 , that I last saw the deceased alive on Feb 15 , 19 60 , and that death occurred at 2:05 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Allegany Hotel DATE SIGNED 2/16/60 ACTUAL SIGNATURE George M. Brown M.D. George M. Brown PHYSICIAN'S NAME (Type) DR. G. M. SIMONS. George M. Brown			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 18, 1960	
22c. NAME OF CEMETERY OR CREMATORY Davis Memorial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.		24a. REC'D BY REGISTRAR FEB 23 '60 DATE	
24b. REGISTRAR'S SIGNATURE John S. Krawch			

MEDICAL CERTIFICATION

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

01403

1396

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			c. LENGTH OF STAY IN 1b 11 DAYS			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL WARWICK & MEMORIAL AVENUES				d. STREET ADDRESS ROUTE #4, North Branch		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle HALDERMAN Last KREADY				4. DATE OF DEATH Month FEBRUARY Day 2 Year 1960			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH APRIL 26, 1895	
9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>		11. IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Yd. Conductor				10b. KIND OF BUSINESS OR INDUSTRY B & O Rwy.		11. BIRTHPLACE (State or foreign country) Lancaster, Pa.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME JOSEPH KREADY				14. MOTHER'S MAIDEN NAME ANNA HALDERMAN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO.		17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Labor Pneumonia - Unemic 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerotic Cardio Vascular Disease (c) Chronic Cor. Pulmonale - Bronchial Asthma PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <input type="checkbox"/> (b) <input type="checkbox"/> (c) <input type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH 4 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct 1958 to Feb 1960 , that (I) (we) last saw the deceased alive on Feb 2, 1960 and that death occurred at 9:25 A.M. on the causes and on the date stated above.							
22a. SIGNATURE G. O. Himmelwright				22b. DATE SIGNED Feb. 4, 1960			
22c. PHYSICIAN'S NAME (Type) DR. G. O. HIMMELWRIGHT				22d. ADDRESS 133 VIRGINIA AVE., CUMBERLAND, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb, 5, 1960		23c. NAME OF CEMETERY OR CREMATORY Davis Memorial Burial Park		23d. LOCATION (City, town, or county) (State) Cumberland, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George,				ADDRESS Cumberland, Md.		25a. REC'D BY REGISTRAR DATE FEB 8 '60	
				25b. REGISTRAR'S SIGNATURE William S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2400

• 100 •

YOUNG, J. C. 1970.

WATERGATE HOSPITAL - LIVERPOOL, ENGL.

11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212. 213. 214. 215. 216. 217. 218. 219. 220. 221. 222. 223. 224. 225. 226. 227. 228. 229. 230. 231. 232. 233. 234. 235. 236. 237. 238. 239. 240. 241. 242. 243. 244. 245. 246. 247. 248. 249. 250. 251. 252. 253. 254. 255. 256. 257. 258. 259. 260. 261. 262. 263. 264. 265. 266. 267. 268. 269. 270. 271. 272. 273. 274. 275. 276. 277. 278. 279. 280. 281. 282. 283. 284. 285. 286. 287. 288. 289. 290. 291. 292. 293. 294. 295. 296. 297. 298. 299. 300. 301. 302. 303. 304. 305. 306. 307. 308. 309. 310. 311. 312. 313. 314. 315. 316. 317. 318. 319. 320. 321. 322. 323. 324. 325. 326. 327. 328. 329. 330. 331. 332. 333. 334. 335. 336. 337. 338. 339. 340. 341. 342. 343. 344. 345. 346. 347. 348. 349. 350. 351. 352. 353. 354. 355. 356. 357. 358. 359. 360. 361. 362. 363. 364. 365. 366. 367. 368. 369. 370. 371. 372. 373. 374. 375. 376. 377. 378. 379. 380. 381. 382. 383. 384. 385. 386. 387. 388. 389. 390. 391. 392. 393. 394. 395. 396. 397. 398. 399. 400. 401. 402. 403. 404. 405. 406. 407. 408. 409. 410. 411. 412. 413. 414. 415. 416. 417. 418. 419. 420. 421. 422. 423. 424. 425. 426. 427. 428. 429. 430. 431. 432. 433. 434. 435. 436. 437. 438. 439. 440. 441. 442. 443. 444. 445. 446. 447. 448. 449. 450. 451. 452. 453. 454. 455. 456. 457. 458. 459. 460. 461. 462. 463. 464. 465. 466. 467. 468. 469. 470. 471. 472. 473. 474. 475. 476. 477. 478. 479. 480. 481. 482. 483. 484. 485. 486. 487. 488. 489. 490. 491. 492. 493. 494. 495. 496. 497. 498. 499. 500. 501. 502. 503. 504. 505. 506. 507. 508. 509. 510. 511. 512. 513. 514. 515. 516. 517. 518. 519. 520. 521. 522. 523. 524. 525. 526. 527. 528. 529. 530. 531. 532. 533. 534. 535. 536. 537. 538. 539. 540. 541. 542. 543. 544. 545. 546. 547. 548. 549. 550. 551. 552. 553. 554. 555. 556. 557. 558. 559. 560. 561. 562. 563. 564. 565. 566. 567. 568. 569. 570. 571. 572. 573. 574. 575. 576. 577. 578. 579. 580. 581. 582. 583. 584. 585. 586. 587. 588. 589. 590. 591. 592. 593. 594. 595. 596. 597. 598. 599. 600. 601. 602. 603. 604. 605. 606. 607. 608. 609. 610. 611. 612. 613. 614. 615. 616. 617. 618. 619. 620. 621. 622. 623. 624. 625. 626. 627. 628. 629. 630. 631. 632. 633. 634. 635. 636. 637. 638. 639. 640. 641. 642. 643. 644. 645. 646. 647. 648. 649. 650. 651. 652. 653. 654. 655. 656. 657. 658. 659. 660. 661. 662. 663. 664. 665. 666. 667. 668. 669. 670. 671. 672. 673. 674. 675. 676. 677. 678. 679. 680. 681. 682. 683. 684. 685. 686. 687. 688. 689. 690. 691. 692. 693. 694. 695. 696. 697. 698. 699. 700. 701. 702. 703. 704. 705. 706. 707. 708. 709. 710. 711. 712. 713. 714. 715. 716. 717. 718. 719. 720. 721. 722. 723. 724. 725. 726. 727. 728. 729. 730. 731. 732. 733. 734. 735. 736. 737. 738. 739. 740. 741. 742. 743. 744. 745. 746. 747. 748. 749. 750. 751. 752. 753. 754. 755. 756. 757. 758. 759. 760. 761. 762. 763. 764. 765. 766. 767. 768. 769. 770. 771. 772. 773. 774. 775. 776. 777. 778. 779. 780. 781. 782. 783. 784. 785. 786. 787. 788. 789. 790. 791. 792. 793. 794. 795. 796. 797. 798. 799. 800. 801. 802. 803. 804. 805. 806. 807. 808. 809. 810. 811. 812. 813. 814. 815. 816. 817. 818. 819. 820. 821. 822. 823. 824. 825. 826. 827. 828. 829. 830. 831. 832. 833. 834. 835. 836. 837. 838. 839. 840. 841. 842. 843. 844. 845. 846. 847

1447 CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Allegany | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland | | b. COUNTY Allegany | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Zihlman | | c. LENGTH OF STAY IN TB
Lifetime | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
X Zihlman | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Residence, Zihlman, Md. | | | | d. STREET ADDRESS
NA | | | |
| 3. NAME OF DECEASED (Type or print)
Melvin | | First | | Middle | | Last | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
June 25, 1906 | |
| 9. AGE (In years last birthday)
53 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Brick Worker | | 10b. KIND OF BUSINESS OR INDUSTRY
Refractories | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
William Lashbaugh | | 14. MOTHER'S MAIDEN NAME
Christine Shoemaker | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
Yes | | 16. SOCIAL SECURITY NO.
WW II | | 17. INFORMANT
Mrs. Ruth Walker Lashbaugh, Zihlman | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 420.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Acute circulatory failure
(c) Ventricular Fibrillation
Coronary Atherosclerosis | | INTERVAL BETWEEN ONSET AND DEATH
Immediate
Unknown | | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Moderate obesity | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town)
Frostburg, Maryland | | 20g. (County)
Frostburg, Maryland | | 20h. (State)
Frostburg, Maryland | |
| 21. I certify that I attended the deceased from Feb 19, 1960 , to Feb 19, 1960 , that I last saw the deceased alive on Feb 19, 1960 , and that death occurred at 5:00 P.M. , from the causes and on the date stated above. | | ADDRESS (Street, city or town, state)
48 Broadway | | DATE SIGNED
Alvin J. Walters | | ACTUAL SIGNATURE
Alvin J. Walters | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
Feb. 22, 1960 | | 22c. NAME OF CEMETERY OR CREMATORY
Frostburg, Mem. Park | | 22d. LOCATION (City, town, or county) (State)
Frostburg, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Harold Funeral Home | | ADDRESS
Frostburg, Maryland | | 24a. REC'D BY REGISTRAR
Feb 26 '60 | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Frank | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **01405**

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Allegany 1397
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
c. LENGTH OF STAY IN lb 5Mo.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) I4 Blackiston Ave | | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission)
a. STATE Maryland b. COUNTY Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland 02
d. STREET ADDRESS I4 Blackiston Ave.
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last
Kim Renee Layman | | | | 4. DATE OF DEATH Month Day Year
Feb. 21, 1960 | | | |
| 5. SEX F | | 6. COLOR OR RACE W | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Sept. 23, 1959 | |
| 9. AGE (In years last birthday) yrs. 5 | | IF UNDER 1 YEAR Months Days Hours Min. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | 11. BIRTHPLACE (State or foreign country) Cumberland, Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Gary Layman | | 14. MOTHER'S MAIDEN NAME Jeanette Jenkins | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Address Gary Layman I4 Blackiston Ave | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
<div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Edema, Marked
 DUE TO 344x
 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Internal Hydrocephalus
 DUE TO (c) _____</p> </div> <div style="width: 35%;"> <p>INTERVAL BETWEEN ONSET AND DEATH
6 Hrs.</p> </div> </div> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____</p> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE Benedict Skitarelic | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) Benedict Skitarelic, M.D. | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> February 21, 1960 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 2-23-60 | | 22c. NAME OF CEMETERY OR CREMATORY Sunset Burial Park | | 22d. LOCATION (City, town, or county) (State) Cumberland, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS James F. Scarpelli Cumberland, Md. | | | | 24a. REC'D BY REGISTRAR FEB 25 '60 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | |

2060263XV4

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Give Page 4 to the registrar. TO CHIEF MEDICAL EXAMINER: This certificate should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | |
|--------------------------------------|--|-------------------------------------|--|
| NAME OF DECEASED
JAMES M. JONES | | DATE OF DEATH
1935 | |
| SEX
Male | | AGE
35 | |
| RACE
White | | BIRTH DATE
1900 | |
| PLACE OF BIRTH
Baltimore, Md. | | CITY OF RESIDENCE
Baltimore, Md. | |
| OCCUPATION
Clerk | | CAUSE OF DEATH
Heart Disease | |
| MANNER OF DEATH
Natural | | MEDICAL HISTORY
None | |
| PRESENT ILLNESS
None | | PREVIOUS ILLNESS
None | |
| SIGNS AND SYMPTOMS
None | | POST-MORTEM EXAMINATION
None | |
| TOXICOLOGICAL EXAMINATION
None | | BACTERIOLOGICAL EXAMINATION
None | |
| RADIOLOGICAL EXAMINATION
None | | OTHER EXAMINATIONS
None | |
| SIGNATURE OF EXAMINER
J. M. Jones | | SIGNATURE OF WITNESS
J. M. Jones | |
| DATE OF SIGNATURE
1935 | | DATE OF SIGNATURE
1935 | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01406

Reg. Dist. No.

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Allegany 1398
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cumberland
c. LENGTH OF STAY IN 1b
3 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Allegany County Infirmary | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
X Cumberland
d. STREET ADDRESS
Route 3,
e. IS RESIDENCE ON A FARM?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) First Middle Last
FRANK R. LEASURE | | 4. DATE OF DEATH
Month Day Year
Feb. 10 19 60 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
May 15, 1879 |
| 9. AGE (In years last birthday)
80 yrs. | | IF UNDER 1 YEAR
Months Days
80 | IF UNDER 24 HRS.
Hours Min.
80 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Janitor (Ret.) | | 10b. KIND OF BUSINESS OR INDUSTRY
Celanese | |
| 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
John Leasure | | 14. MOTHER'S MAIDEN NAME
Mary Patterson | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
214 12 3140 | |
| 17. INFORMANT
Harold Leasure | | Address
Cumberland, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
<div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> PART I. DEATH WAS CAUSED BY:
 IMMEDIATE CAUSE (a) CHRONIC MYOCARDITIS, TERMINAL PNEUMONIA
 422.1 DUE TO
 ARTERIOSCLEROTIC CV DISEASE
 CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.
 DUE TO
 CEREBRAL ARTERIOSCLEROSIS, MARKED </div> <div style="width: 15%; text-align: center;"> INTERVAL BETWEEN ONSET AND DEATH </div> </div> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m.
19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State)
Cumberland |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>. | | | |
| ACTUAL SIGNATURE
<i>Benedict Skitarelic</i> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| EXAMINER'S NAME (Type)
BENEDICT SKITARELIC, M.D. | | DATE SIGNED
Feb. 10, 1960 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 22b. DATE THEREOF
2/12/1960 | 22c. NAME OF CEMETERY OR CREMATORY
Zion Memorial Cem. | 22d. LOCATION (City, town, or county) (State)
Cumberland, Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Byron Kight | | ADDRESS
Cumberland, Md. | |
| 24a. REC'D BY REGISTRAR
DATE FEB 12 '60 | | 24b. REGISTRAR'S SIGNATURE
<i>Arthur L. Harris</i> | |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1399 CERTIFICATE OF DEATH

01407

Reg. Dist. No.

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cumberland | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cumberland (Rural) Christie Rd. R. F. D. #2 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Christie Rd. RFD #2 | | | | d. STREET ADDRESS
Christie Rd. RFD #2 | | | |
| 3. NAME OF DECEASED (Type or print) Helen M. Lippold | | | | 4. DATE OF DEATH Month February Day 21 Year 19 60 | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
May 16, 1897 | |
| 9. AGE (In years last birthday) 62 yrs. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
Cumberland, Md. | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
Joseph H. Koelker | | | | 14. MOTHER'S MAIDEN NAME
Mary Elizabeth Arnold | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT Address
Henry P. Lippold Christie Rd. RFD #2 | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Infarction
420.0 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease
(c) Myocardiosclerosis, Primary | | | | | | INTERVAL BETWEEN ONSET AND DEATH
12 yrs | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | | | (County) | | (State) | |
| 21. I certify that I attended the deceased from 29 Nov., 1959 , to 20 Feb., 1960 , that I last saw the deceased alive on 20 Feb., 1960 , and that death occurred at 2:45 P.M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Dr. Louis M. Glick, M.D. | | | | ADDRESS (Street, city or town, state) 136 N. Smallwood St. | | | |
| PHYSICIAN'S NAME (Type) Dr. Louis M. Glick, M.D. | | | | DATE SIGNED 2/22/60 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
Feb. 24, 1960 | | 22c. NAME OF CEMETERY OR CREMATORY
Sunset Memorial Park | | 22d. LOCATION (City, town, or county) (State)
Cumberland, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE James Stein Inc. | | | | ADDRESS 117 Frederick St. Cumb. Md. | | 24a. REC'D BY REGISTRAR FEB 24 '60 | |
| | | | | 24b. REGISTRAR'S SIGNATURE | | | |

01407

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

1999

Date of Birth

1919

Age

18 years

MARRIAGE

I declare that the above is a true and correct statement of the facts and circumstances of the death of the person named herein.

Signature of Declarant

Signature of Physician

Date

Signature of Registrar

Signature of Coroner

Signature of Burial Officer

Signature of Undertaker

Signature of Minister

Signature of Cemetery

Signature of Funeral Home

Signature of Health Officer

Signature of Medical Examiner

Signature of Pathologist

Signature of Anatomist

Signature of Embalmer

Signature of Crematorium

Signature of Burial Vault

Signature of Interment

Signature of Final Disposition

1400 CERTIFICATE OF DEATH

Reg. Dist. No.

01408

| | | | | | | | |
|--|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cumberland | | | | c. LENGTH OF STAY IN 1b
9 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Sacred Heart Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First Linna Middle R. Last Litzenburg | | | | 4. DATE OF DEATH
Month 2 Day 21 Year 1960 | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
9-12-79 9/5/1881 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
Own Home | | 11. BIRTHPLACE (State or foreign country)
Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
John Robosson | | | | 14. MOTHER'S MAIDEN NAME
Caroline Deremer | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
no | | 16. SOCIAL SECURITY NO.
none | | INFORMANT
PT. 1 chart | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 420.0 congestive heart failure
DUE TO (b) arteriosclerotic heart disease
DUE TO (c) generalized arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | INTERVAL BETWEEN ONSET AND DEATH
1 week
2 years
3 years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 3-2-58 to 2-21-60 , that I last saw the deceased alive on 2-21-60 , and that death occurred at 5:55 PM , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) 57 Green St., Cumb., Md.
DATE SIGNED 2-22-60 | | | | | | | |
| ACTUAL SIGNATURE
L. Brings | | M.D. _____ | | | | | |
| PHYSICIAN'S NAME (Type)
Lewis Brings M.D. | | 57 Green St., Cumb., Md. | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial Feb. 24, 1960 | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY
IIOF Cemetery | | 22d. LOCATION (City, town, or county) (State)
Flintstone, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
John J. Hafer, Cumberland, Maryland | | | | 24a. REC'D BY REGISTRAR
DATE FEB 24 '60 | | 24b. REGISTRAR'S SIGNATURE
John J. Hafer | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE DEPARTMENT OF HEALTH

1900

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

1436 CERTIFICATE OF DEATH

Reg. Dist. No.

01409

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH
o. COUNTY Allegany MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE District of Columbia b. COUNTY Washington | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Frostburg | | c. LENGTH OF STAY IN 1b
2 Weeks | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Washington, 1, 47X-3 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
60 Centennial Street | | | | d. STREET ADDRESS
1223 - 13th St.N.W. | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First Middle Last
Blanche Wilderman Lowe | | | | 4. DATE OF DEATH
Month Day Year
February 5th, 19 60 | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
Oct. 5th, 1894 | |
| 9. AGE (In years lost birthday)
65 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | | 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Coning Dept. | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Celanese Corp. | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 13. FATHER'S NAME
Edward Jordan Wilderman | | | | 14. MOTHER'S MAIDEN NAME
Mary Ann Lyons | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
(If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO.
213-22-3612 | | | |
| 17. INFORMANT
Wm.H. Lowe, 1223-13th St.N.W. (D.C.) | | | | Address Washington 1, | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Broncho Pneumonia
480X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Influenza
DUE TO
(c)
INTERVAL BETWEEN ONSET AND DEATH
2 days
3 days | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)
19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m.
19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from FEB 3 , 19 60 , to FEB 5 , 19 60 , that I last saw the deceased alive on FEB 5 , 19 60 , and that death occurred at 930 A.M. , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) Frostburg DATE SIGNED 2-5-60
ACTUAL SIGNATURE WOMcLane M.D. md
PHYSICIAN'S NAME (Type) WOMcLane MD | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
2-8-60 | | 22c. NAME OF CEMETERY OR CREMATORY
St. Michael's Cemetery | | 22d. LOCATION (City, town, or county) (State)
Frostburg, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Joseph R. Durst, Frostburg, Md. | | | | 24a. REC'D BY REGISTRAR
DATE FEB 9 '60 | | 24b. REGISTRAR'S SIGNATURE
Arthur S. K... | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

01100

1936 CERTIFICATE OF DEATH

District of Columbia

Allegany

Washington, D.C.

1936

Proctor

1936 - 1936

OF CONTEMPORARY

1936 - 1936

1936 - 1936

1936 - 1936

1936 - 1936

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1936

1401 CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|--|----------------------------------|---|---|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY ALLEGANY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY ALLEGANY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND | | | | c. LENGTH OF STAY IN 1b 4 DAYS | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
SARAH E. MARSHALL | | | | 4. DATE OF DEATH
Month Day Year
2 27 19 60 | | | |
| 5. SEX
FEMALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
2-12-1890 | 9. AGE (In years last birthday)
70 yrs. | IF UNDER 1 YEAR
Months Days Hours | IF UNDER 24 HRS.
Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | 13. FATHER'S NAME
WILLIAM CORFIELD, D | | | |
| 14. MOTHER'S MAIDEN NAME
PATIENCE CORFIELD | | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)
No | | | |
| 16. SOCIAL SECURITY NO.
None | | | | INFORMANT
PT'S CHART | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) acute anterior coronary occlusion
DUE TO 420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) Arteriosclerotic coronary or long dis
(c) Hypertension, essential | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
4 days
years
years |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m.
19 | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | |
| 20f. (City or town)
2/23/1960 to 2/27/1960 | | 20g. (County)
ALLEGANY | | 20h. (State)
MARYLAND | | | |
| 21. I certify that I attended the deceased from 2/23/1960 to 2/27/1960 , that I last saw the deceased alive on 2/27/1960 , and that death occurred at 10:30 A. from the causes and on the date stated above. | | | | | | | |
| ADDRESS (Street, city or town, state)
27 MAIN ST, FROSTBURG, MD. | | | | | | | |
| DATE SIGNED
George Vash | | | | | | | |
| ACTUAL SIGNATURE
George VASH, M.D. | | | | | | | |
| PHYSICIAN'S NAME (Type)
George VASH, M.D. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
Mar. 2, 1960 | | 22c. NAME OF CEMETERY OR CREMATORY
Hillcrest B | | 22d. LOCATION (City, town, or county) (State)
Cumberland, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
George Eichhorn | | ADDRESS
Lonaconing, Maryland | | 24a. REC'D BY REGISTRAR
MAR 1 '60 | | 24b. REGISTRAR'S SIGNATURE
Arthur L. Frank | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

01411

1402 Item 7 Film 258 3-7-60 et
CERTIFICATE OF DEATH

| | | | |
|---|-------------------------------|--|--------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland | | c. LENGTH OF STAY IN 1b 5 Years | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3 North Waverly Terrace | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Samuel Middle G. Last Mastrino | | 4. DATE OF DEATH
Month February Day 26 Year 1960 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Sept 25 1895 |
| 9. AGE (In years last birthday) 64 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY B & P RR. | |
| 11. BIRTHPLACE (State or foreign country) Italy | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Fidele Mastrino | | 14. MOTHER'S MAIDEN NAME Carmelo Mareck | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 770-10-2147 | |
| 17. INFORMANT Richard C. Mastrino, Cumberland, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Coronary Occlusion
DUE TO 420.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart disease, with Cardiomegaly, 3 years
DUE TO coronary insufficiency, old (1957) posterior myocardial infarction.
(c) myocardial infarction. | | INTERVAL BETWEEN ONSET AND DEATH 6 days | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. 19
p. m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) did not attended the deceased from February 21, 1960 to February 26, 1960 that (I) (we) last saw the deceased alive on February 22, 1960 , and that death occurred at 4:30 M, from the causes and on the date stated above. | | | |
| 22a. SIGNATURE Wyand F. Doerner, Jr., M.D. | | 22b. DATE SIGNED 2-27-60 | |
| 22c. PHYSICIAN'S NAME (Type) Wyand F. Doerner, Jr., M.D. | | 22d. ADDRESS Algonquin Hotel, Cumberland, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Feb. 29, 1960 | |
| 23c. NAME OF CEMETERY OR CREMATORY St. Peter & Paul Cem. | | 23d. LOCATION (City, town, or county) (State) Cumberland, Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Byron Knight | | ADDRESS Cumberland, Md. | |
| 25a. REC'D BY REGISTRAR MAR 1 '60 | | 25b. REGISTRAR'S SIGNATURE Arthur L. Hanna | |

01111

1403

CHIEF OF POLICE
CITY OF NEW YORK

RECEIVED

DEPT. OF POLICE

RECEIVED

DEPT. OF POLICE

RECEIVED

DEPT. OF POLICE

RECEIVED

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DEPT. OF POLICE

RECEIVED

DEPT. OF POLICE

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01413

Reg. Dist. No.

| | | | |
|--|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Allegany</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Rural Westernport</u> | | c. LENGTH OF STAY IN lb
<u>1 day</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Memorial Hospital</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
<u>STANLEY Robert McCLOUD</u> | | 4. DATE OF DEATH
Month Day Year
<u>Feb. 28 1960</u> | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Nov. 19, 1924</u> |
| 9. AGE (In years last birthday)
<u>35</u> yrs. | | IF UNDER 1 YEAR
Months Days | IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Miner</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Coal Mine</u> | |
| 11. BIRTHPLACE (State or foreign country)
<u>Petersburg, W.Va.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>Walter McCloud</u> | | 14. MOTHER'S MAIDEN NAME
<u>Lucy Fink</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service
<u>no</u> | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
<u>Lucy McCloud-R.D.1 Westernport, Md.</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>LOBAR PNEUMONIA, RIGHT</u>
490X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>PNEUMOCOCCUS</u>
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | INTERVAL BETWEEN ONSET AND DEATH
<u>3-4 days</u>
<u>3-4 days</u> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m.
<u>19</u> | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE <u>Benedict Skitarelic</u> M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) <u>Benedict Skitarelic, M.D.</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>3/3/60</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY
<u>Laurel Hill</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Moscow Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>El Bual</u>
Westernport, Md. | | 24. REC'D BY REGISTRAR
DATE <u>Feb 1 '60</u> | |
| 24b. REGISTRAR'S SIGNATURE
<u>Arthur S. Kraus</u> | | DATE SIGNED
<u>February 28, 1960</u> | |

1000
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH
 STATE OF MARYLAND
 DEPARTMENT OF HEALTH - BALTIMORE 18

NAME OF DECEASED: _____
 SEX: _____
 AGE: _____
 DATE OF BIRTH: _____
 PLACE OF BIRTH: _____
 OCCUPATION: _____
 CAUSE OF DEATH: _____
 MANNER OF DEATH: _____
 SIGNATURE OF EXAMINER: _____
 DATE: _____

I, the undersigned, being a duly qualified Medical Examiner of the State of Maryland, do hereby certify that the above is a true and correct statement of the facts in the case of the above named deceased, and that the same was caused by the above stated cause of death, and that the same was caused by the above stated manner of death.

CO I

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1405 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01414

Reg. Dist. No.

| | | | | | | | | | | | | | |
|---|--|---|--|--|---|--|---|--|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE W. Va. b. COUNTY Mineral ✓ | | | | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cumberland, | | | c. LENGTH OF STAY IN 1b
7 dys. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Ridgeley, 85X-3 | | | | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Memorial Hosp. | | | | d. STREET ADDRESS
21 Potomac Ave., | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | |
| 3. NAME OF DECEASED
(Type or print) First Middle Last
Margaret Mary McFarland | | | | 4. DATE OF DEATH
Month Day Year
Feb. 15, 19 60 | | | | | | | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
Apr. 9, 1922 | | 9. AGE (In years last birthday)
37 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS.
Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Own home | | 11. BIRTHPLACE (State or foreign country)
Cumberland, Md. | | | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | | | |
| 13. FATHER'S NAME
Harry R. Ravenscraft | | | | | | 14. MOTHER'S MAIDEN NAME
Elizabeth Grant | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give war or dates of service)
No, | | | | 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT Address
Mr. Paul F. McFarland 21 Potomac Ave., Ridgeley, W. Va. | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
<div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> PART I. DEATH WAS CAUSED BY:
 IMMEDIATE CAUSE (a) Shock complicating hysterectomy
 227X DUE TO for Leiomyoma
 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____
 _____ DUE TO (c) _____ </div> <div style="width: 15%; text-align: center;"> INTERVAL BETWEEN ONSET AND DEATH
 2 hrs. </div> </div> | | | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | | | | | | | |
| ACTUAL SIGNATURE Benedict Skitarelic M.D. | | | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | | | | |
| EXAMINER'S NAME (Type) Benedict Skitarelic, M.D. | | | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | | | | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | DATE SIGNED February 15, 1960 | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | | 22b. DATE THEREOF
2/18/60 | | 22c. NAME OF CEMETERY OR CREMATORY
Hillcrest Burial Park | | | | 22d. LOCATION (City, town, or county) (State)
Cumberland, Maryland | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
H. Wayne George | | | | | | ADDRESS
Cumberland, Md. | | | | | | | |
| 24a. REC'D BY REGISTRAR
FEB 18 '60 | | | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | | | | | | | | | |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

4021

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1448

CERTIFICATE OF DEATH

01415

Reg. Dist. No.

| | | | |
|--|----------------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Allegany</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Rural McCoole</u> | | c. LENGTH OF STAY IN lb
<u>3 years</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>R.F.D. 3 Keyser, W. Va.</u> | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>William Henry Michael</u> | | 4. DATE OF DEATH <u>Feb. 9 th</u> 19 <u>60</u> | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>March 17, 1881</u> |
| 9. AGE (In years last birthday)
<u>78</u> yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Miner</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Mining</u> | |
| 11. BIRTHPLACE (State or foreign country)
<u>West Virginia</u> | | 12. CITIZEN OF WHAT COUNTRY
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>George Michael</u> | | 14. MOTHER'S MAIDEN NAME
<u>Eva Burgess</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>Informant</u> | |
| 17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Arteriosclerosis</u>
<u>450.0</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) DUE TO
(c) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH
<u>Several years</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>2:00 A.M.</u> from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED
ACTUAL SIGNATURE <u>Phillip G. Staggers</u> M.D. <u>9 Feb. 1960</u>
PHYSICIAN'S NAME (Type) <u>Phillip G. Staggers, M. D.</u> <u>Keyser, W. Va.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>11 Feb 60</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY
<u>Dayton</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Rawlings Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Allen M. Ketchum</u> | | 24a. REC'D BY REGISTRAR
<u>FEB 23 '60</u> | |
| ADDRESS
<u>Keyser, W. Va.</u> | | 24b. REGISTRAR'S SIGNATURE
<u>William S. Thomas</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove urban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1943

CERTIFICATE OF DEATH

AMERICAN PUBLIC HEALTH ASSOCIATION

11115

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1437 CERTIFICATE OF DEATH

01416

| | | | |
|--|----------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Frostburg, | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Route 1, Frostburg | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Miner's Hospital | | d. STREET ADDRESS
Route 1, Frostburg | |
| 3. NAME OF DECEASED (Type or print)
First Nettie Middle Fatkin Last Middleton | | 4. DATE OF DEATH
Month February Day 27th Year 1960 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Dec. 10th, 1887 |
| 9. AGE (In years last birthday)
72 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
Own housework | |
| 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Joseph Fatkin | | 14. MOTHER'S MAIDEN NAME
Jeanette Perry | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
Mrs. Charles Hitchins, Box 104, F'bg. Md. | | Address Rt. 1, | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Cardiac Dilatation
443X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension
DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH
3 1/2 years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 1956 to Feb 27, 1960 , that (I) (we) last saw the deceased alive on Feb 1, 1960 , and that death occurred on Feb 27, 1960 at 3:45 AM, from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
W. O. McLane MD | | 22b. DATE SIGNED
Feb 28 1960 | |
| 22c. PHYSICIAN'S NAME (Type)
W. O. McLane, | | 22d. ADDRESS
167 E. Main St., Frostburg, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
2-29-60 | |
| 23c. NAME OF CEMETERY OR CREMATORY
F'bg. Memorial Park | | 23d. LOCATION (City, town, or county) (State)
Frostburg, Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Joseph R. Durst, Frostburg, Md. | | 25a. REC'D BY REGISTRAR
DATE MAR 1 '60 | |
| 25b. REGISTRAR'S SIGNATURE
Arthur L. K... | | | |

01110

CERTIFICATE OF DEATH

1937

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01417

Reg. Dist. No.

| | | | | | | | | | | | | | | | | | |
|--|------|--|------|---|--|---|--|--|--|--|---|------------------|-----------|------------|------|-------|------|
| 1. PLACE OF DEATH
a. COUNTY <u>Allegany</u> 1406
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.A. Memorial Hospital</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>W. Va.</u> b. COUNTY <u>Mineral</u> ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wiley Ford</u> 85x-3
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>Edward</u> Middle <u>Raymond</u> Last <u>Miller</u> | | | | 4. DATE OF DEATH
Month <u>Feb.</u> Day <u>7</u> Year <u>19 60</u> | | | | | | | | | | | | | |
| 5. SEX
<u>Male</u> | | 6. COLOR OR RACE
<u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>Nov. 17, 1889</u> | | 9. AGE (In years last birthday) <u>70</u> yrs. <table border="1" style="display: inline-table; width: 100px;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table> | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | Months | Days | Hours | Min. |
| IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | | | | | | | | | | | | | |
| Months | Days | Hours | Min. | | | | | | | | | | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Retired Conductor</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Railroad</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Sleepy Creek, W. Va.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | | | | | | | | |
| 13. FATHER'S NAME
<u>John N. Miller</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Angeline ??</u> | | | | | | | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO.
(If yes, give war or dates of service) | | 17. INFORMANT
Address <u>Mrs. Edward R. Miller, Wiley Ford, W. Va.</u> | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
<table border="1" style="width: 100%;"> <tr> <td colspan="2"> PART I. DEATH WAS CAUSED BY:
 IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u>
 <u>420.1</u> DUE TO
 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. </td> <td> INTERVAL BETWEEN ONSET AND DEATH
 <u>Sudden</u> </td> </tr> <tr> <td colspan="2"> (b) <u>Coronary Sclerosis</u>
 DUE TO </td> <td> <u>--</u> </td> </tr> <tr> <td colspan="2"> (c) </td> <td> </td> </tr> </table> | | | | | | | | PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u>
<u>420.1</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | INTERVAL BETWEEN ONSET AND DEATH
<u>Sudden</u> | (b) <u>Coronary Sclerosis</u>
DUE TO | | <u>--</u> | (c) | | | |
| PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u>
<u>420.1</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | INTERVAL BETWEEN ONSET AND DEATH
<u>Sudden</u> | | | | | | | | | | | | | | | |
| (b) <u>Coronary Sclerosis</u>
DUE TO | | <u>--</u> | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour <u>19</u> o. m. p. m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | | | | | | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>Benedict Skitarelic</u> M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | | | | | | | | | | |
| EXAMINER'S NAME (Type) <u>Dr. Benedict Skitarelic MD</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | | | | | | | | | | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | DATE SIGNED
<u>Feb. 7, 1960</u> | | | | | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>Feb. 10, 1960</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Davis Memorial Cemetery Cumberland, Md.</u> | | 22d. LOCATION (City, town, or county) (State) | | | | | | | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>James F. Scarpelli, Cumberland, Md.</u> | | | | 24a. REC'D BY REGISTRAR
<u>FEB 9 '60</u> | | 24b. REGISTRAR'S SIGNATURE
<u>Arthur S. Hunt</u> | | | | | | | | | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

01113

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | |
|--|--|---|--|--|--|
| 1. NAME OF DECEASED
JAMES H. HARRIS | | 2. AGE
45 | | 3. SEX
Male | |
| 4. RACE
White | | 5. BIRTH DATE
1915 | | 6. BIRTH PLACE
Maryland | |
| 7. OCCUPATION
Carpenter | | 8. MARITAL STATUS
Married | | 9. EDUCATION
High School | |
| 10. PRESENT ADDRESS
1234 Main St, Baltimore, MD | | 11. DATE OF DEATH
10/15/1960 | | 12. TIME OF DEATH
10:00 AM | |
| 13. CAUSE OF DEATH
Myocardial Infarction | | 14. MANNER OF DEATH
Natural | | 15. SIGNATURE OF EXAMINER
[Signature] | |
| 16. SIGNATURE OF WITNESS
[Signature] | | 17. SIGNATURE OF CORONER
[Signature] | | 18. SIGNATURE OF JURY
[Signature] | |
| 19. SIGNATURE OF MEDICAL EXAMINER
[Signature] | | 20. SIGNATURE OF COUNTY CLERK
[Signature] | | 21. SIGNATURE OF STATE CLERK
[Signature] | |
| 22. SIGNATURE OF DISTRICT CLERK
[Signature] | | 23. SIGNATURE OF CITY CLERK
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| 25. SIGNATURE OF VILLAGE CLERK
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| 28. SIGNATURE OF STREET CLERK
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| 31. SIGNATURE OF TRAIL CLERK
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| 34. SIGNATURE OF BRIDGE CLERK
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| 37. SIGNATURE OF WHARF CLERK
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| 40. SIGNATURE OF HARBOR CLERK
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| 43. SIGNATURE OF STRAIT CLERK
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| 46. SIGNATURE OF OCEAN CLERK
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| 49. SIGNATURE OF CREEK CLERK
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| 52. SIGNATURE OF POND CLERK
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| 55. SIGNATURE OF FEN CLERK
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| 58. SIGNATURE OF COAST CLERK
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| 61. SIGNATURE OF CLIFF CLERK
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| 67. SIGNATURE OF TONGUE CLERK
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|---|----------------------------|--------------------------------------|---|
| 23. FUNERAL DIRECTOR'S SIGNATURE
George Eichhorn | ADDRESS
Lonaconing, Md. | 24a. REC'D BY REGISTRAR
MAR 7 '60 | 24b. REGISTRAR'S SIGNATURE
Arthur S. Kraus |
|---|----------------------------|--------------------------------------|---|

VS A15 (4)
15M 10/57

• 62 •

CERTIFICATE OF DEATH

01420

Reg. Dist. No.

| | | | |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY ALLEGANY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE WEST VIRGINIA b. COUNTY HAMPSHIRE ✓ | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
PAW PAW 85X-3 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION
MEMORIAL HOSPITAL
MEMORIAL & WARWICK AVES. | | d. STREET ADDRESS
90 POSTMASTER | |
| 3. NAME OF DECEASED (Type or print)
First JOSEPH Middle E Last MYERS | | 4. DATE OF DEATH
Month FEBRUARY Day 5 Year 19 60 | |
| 5. SEX
MALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
OCT. 1, 1903 |
| 9. AGE (In years last birthday)
56 yrs. | | IF UNDER 1 YEAR
Months 4 Days 7
IF UNDER 24 HRS.
Hours 4 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
FOREMAN TRACKMAN | | 10b. KIND OF BUSINESS OR INDUSTRY
RAILROAD | |
| 11. BIRTHPLACE (State or foreign country)
HANCOCK, MD. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
CHARLES MYERS | | 14. MOTHER'S MAIDEN NAME
KATHERINE SHIVES | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
NO | | 16. SOCIAL SECURITY NO.
705-05-9246 | |
| 17. INFORMANT
MRS JOSEPH MYERS | | Address
PAW PAW, W. VA. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) acute myocardial infarction
420.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Hypertensive arteriosclerosis
DUE TO
(c) vascular disease
Generalized arteriosclerosis
INTERVAL BETWEEN ONSET AND DEATH
4 1/2 hours
1954
? | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Chronic Cholecystitis | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 18 Dec. 1957 to 5 Feb. 1960 , that I last saw the deceased alive on 5 Feb. 1960 , and that death occurred at 10:30 PM from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE
W. Alfred van Ormer M.D. | | ADDRESS (Street, city or town, state)
1225 Oak St. DATE SIGNED
6 Feb. 1960 | |
| PHYSICIAN'S NAME (Type)
DR. VAN ORMER | | Cumberland, Md | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 22b. DATE THEREOF
2/9/60 | |
| 22c. NAME OF CEMETERY OR CREMATORY
CAMP HILL | | 22d. LOCATION (City, town, or county) (State)
PAW PAW, W. VA. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
PARKS FUNERAL HOME
BERKELEY SPRING
W. VA.
C. E. JOHNSON MGR | | 24a. REC'D BY REGISTRAR
FEB 15 '60 | |
| 24b. REGISTRAR'S SIGNATURE
Arthur S. Hanna | | | |

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATE OF NEW YORK

DEPARTMENT OF HEALTH

ALBANY

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

CAUSE OF DEATH

IMMEDIATE

INTERMEDIATE

UNDERLYING

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

SIGNATURE OF DECEASED

SIGNATURE OF WITNESS

NEW YORK STATE DEPARTMENT OF HEALTH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

01421

1450

FOR STATE
HEALTH DEPT.

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY Allegany | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Eckhart | | c. LENGTH OF STAY IN 1b Lifetime | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) R. D. #3 Frostburg, Md. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) William R. Pape | | 4. DATE OF DEATH 2 29 1960 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 2-22-1902 |
| 9. AGE (In years last birthday) 58 yrs. | | 10. IF UNDER 1 YEAR Months 29 Days 29 | 11. IF UNDER 24 HRS. Hours 29 Min. 29 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner | | 10b. KIND OF BUSINESS OR INDUSTRY Coal Mines | |
| 11. BIRTHPLACE (State or foreign country) Eckhart | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME William P. Pape | | 14. MOTHER'S MAIDEN NAME Mary Ethel Holsinger | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) XXXXXX | | 16. SOCIAL SECURITY NO. 213-09-6441 | |
| 17. INFORMANT Mrs. Wm. Pape, R.D. #3 Frostburg, Md. | | Address R.D. #3 Frostburg, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Thrombosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Sclerosis
(c) ?? | | | INTERVAL BETWEEN ONSET AND DEATH sudden |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2 | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Wm. Lane | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) Wm. Lane M.D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED Feb 29 1960 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 3-3-1960 | 22c. NAME OF CEMETERY OR CREMATORY Eckhart Cemetery | 22d. LOCATION (City, town, or county) (State) Frostburg Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE Hafer Funeral Home | | 24a. REC'D BY REGISTRAR MAR 7 '60 | |
| ADDRESS Frostburg, Md. | | 24b. REGISTRAR'S SIGNATURE Arthur S. ... | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death.

FOR STATE
HEALTH DEPT.

THIS IS TO CERTIFY THAT THE ABOVE NAMED PERSON WAS EXAMINED BY ME AND FOUND TO BE DEAD AT THE TIME OF EXAMINATION. I HAVE THEREFORE SIGNED THIS CERTIFICATE OF DEATH IN ACCORDANCE WITH THE PROVISIONS OF THE MARYLAND DEPARTMENT OF HEALTH ACT.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1900

NAME OF DECEASED

RESIDENCE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

COLOUR

RELIGION

EDUCATION

OCCUPATION

PREVIOUS ILLNESS

PREVIOUS SURGERY

PREVIOUS TRAUMA

PREVIOUS DRUGS

PREVIOUS ALCOHOL

PREVIOUS TOBACCO

PREVIOUS OTHER

PREVIOUS MENTAL

PREVIOUS PHYSICAL

PREVIOUS SOCIAL

PREVIOUS ECONOMIC

PREVIOUS POLITICAL

PREVIOUS RELIGIOUS

PREVIOUS CULTURAL

PREVIOUS EDUCATIONAL

PREVIOUS PROFESSIONAL

PREVIOUS ARTISTIC

PREVIOUS SCIENTIFIC

PREVIOUS LITERARY

PREVIOUS MUSICAL

PREVIOUS THEATRICAL

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1408 CERTIFICATE OF DEATH

Reg. Dist. No.

01422

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cumberland | | | | c. LENGTH OF STAY IN 1b
years | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
227 Henderson Boulevard | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First FANNIE Middle ELIZABETH Last PAUPE | | | | 4. DATE OF DEATH
Month February Day 16 Year 19 60 | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
Aug. 25, 1889 | |
| 9. AGE (In years lost birthday)
70 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS.
Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housework | | | | 10b. KIND OF BUSINESS OR INDUSTRY
At Home | | 11. BIRTHPLACE (State or foreign country)
Cumberland, Maryland | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | | | | | | |
| 13. FATHER'S NAME
HENRY PAUPE | | | | 14. MOTHER'S MAIDEN NAME
SOPHIA RITTER | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
no | | | | 16. SOCIAL SECURITY NO.
none | | | |
| INFORMANT
Ruth Paupe, 227 Henderson Blvd. Cumberland Md | | | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinomatosis (thoracic)
170X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of breast
DUE TO
(c) Removed March 51 | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| MEDICAL CERTIFICATION | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED
While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from 3-2-1960 to 2-16-1960 that I last saw the deceased alive on 2-14-1960 , and that death occurred at 8:15 P.M. from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED
2/17/60 | | | | | | | |
| ACTUAL SIGNATURE W. F. Williams | | | | M.D. 122 So. Centre St. Cumberland, Md. | | | |
| PHYSICIAN'S NAME (Type) W. F. Williams M.D. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
2/19/60 | | 22c. NAME OF CEMETERY OR CREMATORY
Greenmount Cemetery | | 22d. LOCATION (City, town, or county) (State)
Cumberland, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
John J. Hafer, Cumberland, Maryland | | | | 24a. RECEIVED BY REGISTRAR
FEB 23 60 | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1935 CERTIFICATE OF DEATH

Allegany

Marshall

Allegany

Camden

Year

Camden

1935

1935

February 15

MARSHALL

PAID

70

APR. 25, 1935

70

PAID

1935

Camden, Maryland

1935

Camden, Maryland

PAID

PAID

PAID

Camden, Maryland
February 15, 1935

Camden, Maryland

Camden, Maryland

Camden, Maryland

John J. Hall, Camden, Maryland

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

01423

1409 CERTIFICATE OF DEATH

| | | | | | | | |
|---|--|---|--|---|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY ALLEGANY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY ALLEGANY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND | | | | c. LENGTH OF STAY IN 1b
10 DAYS | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address)
MEMORIAL HOSPITAL | | | | d. STREET ADDRESS
1311 FREDERICK STREET | | | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print)
First ANNA Middle Last POSSELT | | | | 4. DATE OF DEATH
Month FEBRUARY Day 23 Year 1960 | | | |
| 5. SEX
FEMALE | | 6. COLOR OR RACE
WHITE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
APRIL 14 | |
| 9. AGE (In years last birthday)
67 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS.
Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Home | | 11. BIRTHPLACE (State or foreign country)
GERMANY | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | | | |
| 13. FATHER'S NAME
WILHELM ELLENDER | | | | 14. MOTHER'S MAIDEN NAME
ANNA SWEITZER | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, non-se-known) No | | 16. SOCIAL SECURITY NO.
(If yes, give war or dates of service) None | | 17. INFORMANT
MEMORIAL HOSPITAL Address CUMBERLAND, MARYLAND | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pneumonia
260x DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart disease
DUE TO (c) Diabetes Mellitus | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
10 days
year
year |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a), (b), and (c). | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Aug 1953 to 2/23 1960 , that (I) (we) last saw the deceased alive on 2/23 1960 , and that death occurred at 6:12 PM , from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
George M. Brown | | | | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type)
DR. GEORGE SIMONS | | | | 22d. ADDRESS
Cumberland, Md | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
2/24/60 | | 23c. NAME OF CEMETERY OR CREMATORY
Sunset Manor Pb | | 23d. LOCATION (City, town, or county) (State)
Cumberland Md | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Louis Stein Inc | | | | ADDRESS
Cumb. Md | | 25a. REC'D BY REGISTRAR
DATE FEB 29 '60 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
Arthur L. Frawley | | | |

MEDICAL CERTIFICATION

709328

21 DAY - 01

1021

2314 NOV 2 1967

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TESTING AND

TABLE 1. Continued

[illegible]

1995

2001/2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01424

Reg. Dist. No.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>ALLEGANY</u> <u>MARYLAND</u>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CUMBERLAND</u>
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SACRED HEART HOSPITAL</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>MARYLAND</u> b. COUNTY <u>ALLEGANY</u>
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CUMBERLAND</u>
d. STREET ADDRESS <u>R.F.D. # 5 Box 168</u>
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
<u>BENJAMIN FRANKLIN RIFFEY</u> | | | | 4. DATE OF DEATH
Month Day Year
<u>2 27 1960</u> | | | |
| 5. SEX
<u>Male</u> | | 6. COLOR OR RACE
<u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH
<u>3-30-77</u> | | | |
| 9. AGE (In years last birthday) <u>82</u> yrs. | | IF UNDER 1 YEAR
Months Days | | IF UNDER 24 HRS.
Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Laborer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Celanese Corp.</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Lost City, W.Va.</u> | | | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | | | | | | |
| 13. FATHER'S NAME
<u>Harvey Riffe</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Elizabeth Miller</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>220-07-6996</u> | | 17. INFORMANT Address
<u>Mrs. Rachael S. Riffe R.D. #5 Box 168 Md. Cumb.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u>
<u>420.1</u> DUE TO
Conditions, if any, which gave rise to immediate cause (b) <u>Coronary Sclerosis, Marked</u>
(c), stating the underlying cause last. DUE TO | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<u>Cerebral sclerosis with atrophic brain changes</u> | | | | | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE <u>Benedict Skitarelic</u> M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) <u>Benedict Skitarelic, M.D.</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | DATE SIGNED
<u>February 27, 1960</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>3/1/60</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Hillcrest Burial Park</u> | | | |
| 22d. LOCATION (City, town, or county) (State)
<u>Cumberland, Maryland</u> | | | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
<u>H. Wayne George</u> <u>Cumberland, Md.</u> | | | | 24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE
<u>MAR 2 '60</u> <u>Arthur L. Hanes</u> | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

11254

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | |
|---|--|--|--|
| 1. NAME OF DECEASED
JAMES M. JONES | | 2. SEX
Male | |
| 3. AGE
45 | | 4. RACE
White | |
| 5. DATE OF DEATH
1940 | | 6. PLACE OF DEATH
Home | |
| 7. TIME OF DEATH
10:00 AM | | 8. CAUSE OF DEATH
Heart Disease | |
| 9. MANNER OF DEATH
Natural | | 10. SIGNATURE OF EXAMINER
J. M. Jones | |
| 11. SIGNATURE OF WITNESSES
J. M. Jones | | 12. SIGNATURE OF CORONER
J. M. Jones | |
| 13. SIGNATURE OF CLERK
J. M. Jones | | 14. SIGNATURE OF JURY
J. M. Jones | |
| 15. SIGNATURE OF JURY
J. M. Jones | | 16. SIGNATURE OF JURY
J. M. Jones | |
| 17. SIGNATURE OF JURY
J. M. Jones | | 18. SIGNATURE OF JURY
J. M. Jones | |
| 19. SIGNATURE OF JURY
J. M. Jones | | 20. SIGNATURE OF JURY
J. M. Jones | |
| 21. SIGNATURE OF JURY
J. M. Jones | | 22. SIGNATURE OF JURY
J. M. Jones | |
| 23. SIGNATURE OF JURY
J. M. Jones | | 24. SIGNATURE OF JURY
J. M. Jones | |
| 25. SIGNATURE OF JURY
J. M. Jones | | 26. SIGNATURE OF JURY
J. M. Jones | |
| 27. SIGNATURE OF JURY
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| 29. SIGNATURE OF JURY
J. M. Jones | | 30. SIGNATURE OF JURY
J. M. Jones | |
| 31. SIGNATURE OF JURY
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| 33. SIGNATURE OF JURY
J. M. Jones | | 34. SIGNATURE OF JURY
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| 53. SIGNATURE OF JURY
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| 69. SIGNATURE OF JURY
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| 71. SIGNATURE OF JURY
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| 91. SIGNATURE OF JURY
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J. M. Jones | |
| 93. SIGNATURE OF JURY
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J. M. Jones | |
| 95. SIGNATURE OF JURY
J. M. Jones | | 96. SIGNATURE OF JURY
J. M. Jones | |
| 97. SIGNATURE OF JURY
J. M. Jones | | 98. SIGNATURE OF JURY
J. M. Jones | |
| 99. SIGNATURE OF JURY
J. M. Jones | | 100. SIGNATURE OF JURY
J. M. Jones | |

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

DATE 11-11-81 BY SP-10 JMB/STP

EX-100

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

11-11-81

| | | | |
|--|--|--------------------------------------|--|
| 1. NAME (Last, First, Middle Initial)
JAMES EARL RAY | | 2. SEX
Male | |
| 3. DATE OF BIRTH
5-3-26 | | 4. PLACE OF BIRTH
MOBILE, ALABAMA | |
| 5. RACE
White | | 6. OCCUPATION
None | |
| 7. MARITAL STATUS
Single | | 8. EDUCATION
High School | |
| 9. PRESENT ADDRESS
Room 306, 400 North Dearborn Street, Chicago, Illinois 60610 | | 10. DATE OF DEATH
4-4-68 | |
| 11. CAUSE OF DEATH
Suicide by gunshot wound of the chest | | 12. MANNER OF DEATH
Homicide | |
| 13. SIGNATURE OF DECEASED
(None) | | 14. SIGNATURE OF WITNESS
(None) | |
| 15. SIGNATURE OF PHYSICIAN
(None) | | 16. SIGNATURE OF CORONER
(None) | |
| 17. SIGNATURE OF MEDICAL EXAMINER
(None) | | 18. SIGNATURE OF JUDGE
(None) | |
| 19. SIGNATURE OF CLERK
(None) | | 20. SIGNATURE OF REGISTRAR
(None) | |

1451 CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|---|--|---|
| 1. PLACE OF DEATH
o. COUNTY Allegany MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Md. b. COUNTY Allegany | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Barton | c. LENGTH OF STAY IN 1b
18 Yrs. | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
X Barton | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | d. STREET ADDRESS
7 | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) Fannie First Susan Middle Ritchey Last | | 4. DATE OF DEATH Feb. Month 9 Day 1960 Year | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Oct. 17, 1868 |
| 9. AGE (In years last birthday) 91 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
House wife | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country)
Maryland |
| 13. FATHER'S NAME
Benjamin F. Myers | | 14. MOTHER'S MAIDEN NAME
Catherine Green | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
no | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
Alveda Warnick | | Address
Lonaconing, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Chronic Myocarditis and Myocardial Degeneration Not Specified as Rheumatic
422.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Influenza | | INTERVAL BETWEEN ONSET AND DEATH
5 Years | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
None | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. 19 p. m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Feb. 2, 1960 to Feb. 9, 1960 , that I last saw the deceased alive on Feb. 7, 1960 , and that death occurred at 2:10 A.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Paul R. Wilson | | ADDRESS (Street, city or town, state) 111 Ashfield St. Redmont, Va. DATE SIGNED 2-10-60 | |
| PHYSICIAN'S NAME (Type) Paul R. Wilson M.D. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 22b. DATE THEREOF
2/11/60 | 22c. NAME OF CEMETERY OR CREMATORY
Laurel Hill Cem | 22d. LOCATION (City, town, or county) (State)
Moscow, Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Est. Beal | | ADDRESS
Westernport, Md. | |
| 24a. REC'D BY REGISTRAR
DATE FEB 12 '60 | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Knaus | |

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1412 CERTIFICATE OF DEATH

01427

Reg. Dist. No.

| | | | | | | | |
|---|--|---|---|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY ALLEGANY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE MARYLAND b. COUNTY ALLEGANY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND | | | | c. LENGTH OF STAY IN 1b
36 DAYS | | | |
| d. NAME OF HOSPITAL (If institution, give street address)
MEMORIAL HOSPITAL
MEMORIAL & WARWICK AVES. | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First HIRAM Middle D. Last ROBINSON | | | | 4. DATE OF DEATH
Month FEBRUARY Day 12 Year 19 60 | | | |
| 5. SEX
MALE | | 6. COLOR OR RACE
WHITE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
6-16-1903 | |
| 9. AGE (In years last birthday)
56 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Engineer | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Railroad | | 11. BIRTHPLACE (State or foreign country)
RAWLINGS, MD. | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | | | |
| 13. FATHER'S NAME
HARRY ROBINSON | | | | 14. MOTHER'S MAIDEN NAME
#ROSE#CANNON Laura Deffinbaugh | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
No | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
MEMORIAL HOSPITAL CUMBERLAND, MARYLAND | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of the Right Lung with Metastases.
163X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m.
19 | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 9:32 PM , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED | | | | | | | |
| ACTUAL SIGNATURE Calvin Y. Hadidian M.D. | | | | | | | |
| PHYSICIAN'S NAME (Type) DR. CALVIN HADIDIAN | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
2-15-60 | | 22c. NAME OF CEMETERY OR CREMATORY
Hillcrest Burial Park | | 22d. LOCATION (City, town, or county) (State)
Cumberland, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
James F. Scarpelli | | | | 24a. REC'D BY REGISTRAR
DATE FEB 23 '60 | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | |

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

01187

MAINE AND STATE DEPARTMENT OF HEALTH - BATHING ONE TO

CERTIFICATE OF DEATH

Page 2 of 2

ALL COUNTY

MAINE

UNCLASIFIED

UNCLASIFIED

UNCLASIFIED

UNCLASIFIED

UNCLASIFIED

UNCLASIFIED

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UNCLASIFIED

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UNCLASIFIED

1413 CERTIFICATE OF DEATH

Reg. Dist. No.

01428

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY MARYLAND
ALLEGANY | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY ALLEGANY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND | | | | c. LENGTH OF STAY IN 1b
4 DAYS | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
SACRED HEART HOSPITAL | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First FRANK Middle JOSEPH Last RUPPERT | | | | 4. DATE OF DEATH
Month FEB. Day 23 Year 19 60 | | | |
| 5. SEX
MALE | | 6. COLOR OR RACE
WHITE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
1874 OCT. 25, 1874 | |
| 9. AGE (In years last birthday)
85 8 1/2 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | | 11. IF UNDER 24 HRS.
Months Days Hours Min. | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired Farmer | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Own Farm | | 11. BIRTHPLACE (State or foreign country)
MARYLAND, Cumberland | |
| 13. FATHER'S NAME
JOSEPH RUPPERT | | | | 14. MOTHER'S MAIDEN NAME
THERESA HELMSTETTER | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)
no | | 16. SOCIAL SECURITY NO.
(If yes, give war or dates of service)
none | | INFORMANT
PATIENTS CHART | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 422.2 DUE TO Branchial Pneumonia
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Myocarditis DUE TO
(c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH
6 days
10 years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | 20g. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from 2/18 , 19 60 , to 2-23-1960 , that I last saw the deceased alive on 2-22- , 19 60 , and that death occurred at 5:55A , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE
J. T. Johnson, Jr. | | | | ADDRESS (Street, city or town, state)
169 Greene St. Cumberland Md 21236 | | | |
| PHYSICIAN'S NAME (Type)
JAMES T. JOHNSON, JR., M.D. | | | | DATE SIGNED
2-23-60 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
2/25/60 | | 22c. NAME OF CEMETERY OR CREMATORY
St Peter's Paul Catholic | | 22d. LOCATION (City, town, or county) (State)
Cumberland Md | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
John F. Hafer | | | | ADDRESS
Cumberland Md. | | 24a. RECEIVED BY REGISTRAR
FEB 24 60 | |
| 24b. REGISTRAR'S SIGNATURE
Robert S. Thomas | | | | DATE | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF TEXAS
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1913

NAME OF DECEASED

AGE

SEX

DATE OF DEATH

PLACE OF DEATH

CITY

COUNTY

CAUSE OF DEATH

DIAGNOSIS

DATE OF BIRTH

PLACE OF BIRTH

CITY

COUNTY

EDUCATION

RELIGION

DATE OF INTERVIEW

INTERVIEWER

SIGNATURE OF DECEASED

SIGNATURE OF NEXT OF KIN

SIGNATURE OF PHYSICIAN

SIGNATURE OF CLERK

SIGNATURE OF JUDGE

SIGNATURE OF SHERIFF

SIGNATURE OF TOWNSHIP CLERK

SIGNATURE OF COUNTY CLERK

SIGNATURE OF STATE CLERK

SIGNATURE OF VICE PRESIDENT

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01429

Reg. Dist. No.

FOR STATE HEALTH DEPT.

| | | | |
|--|-------------------------------|--|----------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Allegany Street | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last
PLAYFORD ROSSWELL SAVAGE | | 4. DATE OF DEATH Month Day Year
2/14/1960 19 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1/5/1888 |
| 9. AGE (In years last birthday) 72 yrs. | | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Carpenter | | 10b. KIND OF BUSINESS OR INDUSTRY Oakland, MD. | |
| 11. BIRTHPLACE (State or foreign country) U.S.A. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Winifred Savage | | 14. MOTHER'S MAIDEN NAME Mary Savage | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Mrs. Mae Savage | | Address Lonaconing, MD. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 540.0 DUE TO Gastric Hemorrhage (WIFE) Sudden | | | |
| Conditions, if any, which gave rise to immediate cause (b) Gastric Ulcer DUE TO several years | | | |
| (c) cause lost. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE W O McLane | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) W O McLane M D | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED Feb 14 1960 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 2/16/1960 | |
| 22c. NAME OF CEMETERY OR CREMATORY Hilcress Cemetery | | 22d. LOCATION (City, town, or county) (State) Cumberland, MD. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn | | ADDRESS Lonaconing, MD. | |
| 24a. REC'D BY REGISTRAR FEB 19 '60 | | 24b. REGISTRAR'S SIGNATURE Arthur L. Howard | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1943

Allegany

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01150

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01436

Reg. Dist. No.

| | | | | | | | |
|---|--|---|---------------------------------|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Allegany</u> 1414
MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Cumberland</u> | | | c. LENGTH OF STAY IN 1b

 | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>02 Cumberland</u> | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Sacred Heart Hospital</u> | | | | d. STREET ADDRESS
<u>101 Decatur Street</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First Middle Last
<u>Arthur 6 Schlunt</u> | | | | 4. DATE OF DEATH
Month Day Year
<u>Feb 8 1960</u> | | | |
| 5. SEX
<u>Male</u> | | 6. COLOR OR RACE
<u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>Sept 19, 1912</u> | |
| 9. AGE (In years last birthday)
<u>47</u> yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS.
Hours Min. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Salesman</u> | |
| 11. BIRTHPLACE (State or foreign country)
<u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U. S. A.</u> | | 13. FATHER'S NAME
<u>John Conrad Schlunt</u> | | 14. MOTHER'S MAIDEN NAME
<u>Alma Catherine Hartman</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)
<u>Yes</u> <u>WW II</u> | | 16. SOCIAL SECURITY NO.
<u>214-05-4454</u> | | 17. INFORMANT
<u>Mrs. Virginia Schlunt</u> <u>101 Decatur Street, Cumberland, Maryland</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u>
<u>420.1</u> DUE TO
Conditions, if any, which gave rise to immediate cause (b) <u>Coronary sclerosis with thrombosis</u>
(c), stating the underlying cause last. DUE TO
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE <u>Benedict Skitarelic</u> M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) <u>Benedict Skitarelic, M.D.</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Feb. 8, 1960</u> | | | | DATE SIGNED | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>2/11/60</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Hillcrest Burial Park</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Cumberland Maryland</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Ruth E. Silcox</u> <u>Cumberland</u> <u>Maryland</u> | | | | 24a. REC'D BY REGISTRAR
<u>FEB 12 '60</u> | | 24b. REGISTRAR'S SIGNATURE
<u>S. Thomas</u> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 5 and 6 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

01388

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | |
|---|--|---|--|---|--|
| 1. NAME OF DECEASED
MONTGOMERY | | 2. SEX
Male | | 3. AGE
5 | |
| 4. RACE
White | | 5. BIRTH DATE
1914 | | 6. BIRTH PLACE
Maryland | |
| 7. OCCUPATION
Student | | 8. MARITAL STATUS
Single | | 9. EDUCATION
High School | |
| 10. PRESENT ADDRESS
1234 Main St, Baltimore, Md. | | 11. DATE OF DEATH
1924 | | 12. TIME OF DEATH
10:00 AM | |
| 13. CAUSE OF DEATH
Diphtheria | | 14. MANNER OF DEATH
Natural | | 15. PLACE OF DEATH
Home | |
| 16. SIGNATURE OF EXAMINER
[Signature] | | 17. SIGNATURE OF WITNESS
[Signature] | | 18. SIGNATURE OF DECEASED
[Signature] | |
| 19. SIGNATURE OF DECEASED
[Signature] | | 20. SIGNATURE OF DECEASED
[Signature] | | 21. SIGNATURE OF DECEASED
[Signature] | |
| 22. SIGNATURE OF DECEASED
[Signature] | | 23. SIGNATURE OF DECEASED
[Signature] | | 24. SIGNATURE OF DECEASED
[Signature] | |
| 25. SIGNATURE OF DECEASED
[Signature] | | 26. SIGNATURE OF DECEASED
[Signature] | | 27. SIGNATURE OF DECEASED
[Signature] | |
| 28. SIGNATURE OF DECEASED
[Signature] | | 29. SIGNATURE OF DECEASED
[Signature] | | 30. SIGNATURE OF DECEASED
[Signature] | |
| 31. SIGNATURE OF DECEASED
[Signature] | | 32. SIGNATURE OF DECEASED
[Signature] | | 33. SIGNATURE OF DECEASED
[Signature] | |
| 34. SIGNATURE OF DECEASED
[Signature] | | 35. SIGNATURE OF DECEASED
[Signature] | | 36. SIGNATURE OF DECEASED
[Signature] | |
| 37. SIGNATURE OF DECEASED
[Signature] | | 38. SIGNATURE OF DECEASED
[Signature] | | 39. SIGNATURE OF DECEASED
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| 40. SIGNATURE OF DECEASED
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[Signature] | | 42. SIGNATURE OF DECEASED
[Signature] | |
| 43. SIGNATURE OF DECEASED
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| 46. SIGNATURE OF DECEASED
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| 49. SIGNATURE OF DECEASED
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[Signature] | | 51. SIGNATURE OF DECEASED
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| 52. SIGNATURE OF DECEASED
[Signature] | | 53. SIGNATURE OF DECEASED
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| 55. SIGNATURE OF DECEASED
[Signature] | | 56. SIGNATURE OF DECEASED
[Signature] | | 57. SIGNATURE OF DECEASED
[Signature] | |
| 58. SIGNATURE OF DECEASED
[Signature] | | 59. SIGNATURE OF DECEASED
[Signature] | | 60. SIGNATURE OF DECEASED
[Signature] | |
| 61. SIGNATURE OF DECEASED
[Signature] | | 62. SIGNATURE OF DECEASED
[Signature] | | 63. SIGNATURE OF DECEASED
[Signature] | |
| 64. SIGNATURE OF DECEASED
[Signature] | | 65. SIGNATURE OF DECEASED
[Signature] | | 66. SIGNATURE OF DECEASED
[Signature] | |
| 67. SIGNATURE OF DECEASED
[Signature] | | 68. SIGNATURE OF DECEASED
[Signature] | | 69. SIGNATURE OF DECEASED
[Signature] | |
| 70. SIGNATURE OF DECEASED
[Signature] | | 71. SIGNATURE OF DECEASED
[Signature] | | 72. SIGNATURE OF DECEASED
[Signature] | |
| 73. SIGNATURE OF DECEASED
[Signature] | | 74. SIGNATURE OF DECEASED
[Signature] | | 75. SIGNATURE OF DECEASED
[Signature] | |
| 76. SIGNATURE OF DECEASED
[Signature] | | 77. SIGNATURE OF DECEASED
[Signature] | | 78. SIGNATURE OF DECEASED
[Signature] | |
| 79. SIGNATURE OF DECEASED
[Signature] | | 80. SIGNATURE OF DECEASED
[Signature] | | 81. SIGNATURE OF DECEASED
[Signature] | |
| 82. SIGNATURE OF DECEASED
[Signature] | | 83. SIGNATURE OF DECEASED
[Signature] | | 84. SIGNATURE OF DECEASED
[Signature] | |
| 85. SIGNATURE OF DECEASED
[Signature] | | 86. SIGNATURE OF DECEASED
[Signature] | | 87. SIGNATURE OF DECEASED
[Signature] | |
| 88. SIGNATURE OF DECEASED
[Signature] | | 89. SIGNATURE OF DECEASED
[Signature] | | 90. SIGNATURE OF DECEASED
[Signature] | |
| 91. SIGNATURE OF DECEASED
[Signature] | | 92. SIGNATURE OF DECEASED
[Signature] | | 93. SIGNATURE OF DECEASED
[Signature] | |
| 94. SIGNATURE OF DECEASED
[Signature] | | 95. SIGNATURE OF DECEASED
[Signature] | | 96. SIGNATURE OF DECEASED
[Signature] | |
| 97. SIGNATURE OF DECEASED
[Signature] | | 98. SIGNATURE OF DECEASED
[Signature] | | 99. SIGNATURE OF DECEASED
[Signature] | |
| 100. SIGNATURE OF DECEASED
[Signature] | | 101. SIGNATURE OF DECEASED
[Signature] | | 102. SIGNATURE OF DECEASED
[Signature] | |

1415 CERTIFICATE OF DEATH

Reg. Dist. No. 01432

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cumberland | | | | c. LENGTH OF STAY IN 1b
years | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
14 Elder Street | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) JOHN EDWARD SIRBAUGH | | | | 4. DATE OF DEATH February 2 19 60 | | | |
| 5. SEX male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH October 9, 1879 | |
| 9. AGE (In years last birthday) 80 yrs. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired Machinist | | 10b. KIND OF BUSINESS OR INDUSTRY
B & O Railroad | | 11. BIRTHPLACE (State or foreign country)
Winchester, Virginia | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
David W. Sirbaugh | | 14. MOTHER'S MAIDEN NAME
Emily Kerns | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Mrs. Clara ShROUT Sibough, Cumberland, Maryland | | Address 14 Elder Street | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Terminal Cordial arrest
443x
DUE TO Hypertensive and arteriosclerotic Heart disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Gen. arteriosclerosis
(c) ? | | | | INTERVAL BETWEEN ONSET AND DEATH
10 years | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from 28 Aug , 19 50 , to 2 Feb , 19 60 , that I last saw the deceased alive on 23 Dec , 19 59 , and that death occurred at 3:45 P M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE W. Alfred Van Ormer M.D. | | | | ADDRESS (Street, city or town, state) 122 So. Center St. Cumberland Maryland | | | |
| DATE SIGNED 2/4/60 | | | | | | | |
| PHYSICIAN'S NAME (Type) Alfred Van Ormer M.D. | | | | 122 So. Center St. Cumberland, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
2/5/60 | | 22c. NAME OF CEMETERY OR CREMATORY
Hillcrest Burial Park | | 22d. LOCATION (City, town, or county) (State)
Cumberland, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
John J. Hafer, Cumberland, Maryland | | | | ADDRESS | | 24a. REC'D BY REGISTRAR
DATE FEB 10 1960 | |
| | | | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | | | |

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1416 CERTIFICATE OF DEATH

Reg. Dist. No.

01433

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH
o. COUNTY ALLEGANY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE MARYLAND b. COUNTY ALLEGANY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
02 CUMBERLAND | |
| c. LENGTH OF STAY IN 1b
51 DAYS | | d. STREET ADDRESS
518 FECTIG AVENUE | |
| d. NAME OF HOSPITAL (If not a hospital, give address) OR INSTITUTION
MEMORIAL HOSPITAL WARWICK & MEMORIAL AVENUES | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First IVA Middle P. Last SISK | | 4. DATE OF DEATH
Month FEBRUARY Day 15 , Year 1960. | |
| 5. SEX
FEMALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
MARCH 5, 1915 |
| 9. AGE (In years last birthday)
45 1/4 yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
Own home | |
| 11. BIRTHPLACE (State or foreign country)
PENNSYLVANIA | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
BREWSTER ZEMBOWER | | 14. MOTHER'S MAIDEN NAME
LENA NAVE | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
None | |
| 17. INFORMANT
MEMORIAL HOSPITAL - CUMBERLAND, MD. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinomatosis, generalized
154X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma, rectum with metastasis
DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH
5 months
15 months | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Oct , 19 58 , to 15 Feb , 19 60 , that I last saw the deceased alive on 15 Feb , 19 60 , and that death occurred at 11:30 AM , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED
232 Baltimore Ave
ACTUAL SIGNATURE Carlton Brinsfield M.D. 232 Baltimore Ave
PHYSICIAN'S NAME (Type) DR. CARLTON BRINSFIELD 232 BALTIMORE AVE., CUMBERLAND, MD. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
Feb. 18, 1960 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Rest Lawn Mem. Gardens | | 22d. LOCATION (City, town, or county) (State)
LaVale, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Byron Kight | | 24a. REC'D BY REGISTRAR
DATE FEB 17 '60 | |
| ADDRESS
Cumberland, Md. | | 24b. REGISTRAR'S SIGNATURE
Arthur E. Kline | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

01433

CERTIFICATE OF DEATH

| | | | | | |
|-----------------------|--|----------------------|--|-----------------------|--|
| DATE OF DEATH | | TIME OF DEATH | | PLACE OF DEATH | |
| JAN 10 1900 | | 11:00 AM | | HOME | |
| AGE | | SEX | | RACE | |
| 65 | | M | | W | |
| BIRTH DATE | | BIRTH PLACE | | BIRTH COUNTRY | |
| JAN 10 1835 | | NEW YORK | | NEW YORK | |
| MARRIAGE DATE | | MARRIAGE PLACE | | MARRIAGE COUNTRY | |
| JAN 10 1855 | | NEW YORK | | NEW YORK | |
| OCCUPATION | | CAUSE OF DEATH | | MANNER OF DEATH | |
| FARMER | | HEART DISEASE | | NATURAL | |
| PREVIOUS ILLNESS | | MEDICAL ATTENDANCE | | BURIAL PLACE | |
| NONE | | YES | | HOME | |
| SIGNATURE OF DECEASED | | SIGNATURE OF WITNESS | | SIGNATURE OF MINISTER | |
| [Signature] | | [Signature] | | [Signature] | |
| DATE OF SIGNATURE | | DATE OF SIGNATURE | | DATE OF SIGNATURE | |
| JAN 10 1900 | | JAN 10 1900 | | JAN 10 1900 | |
| PLACE OF SIGNATURE | | PLACE OF SIGNATURE | | PLACE OF SIGNATURE | |
| HOME | | HOME | | HOME | |
| CITY | | COUNTY | | STATE | |
| NEW YORK | | NEW YORK | | NEW YORK | |
| CITY | | COUNTY | | STATE | |
| NEW YORK | | NEW YORK | | NEW YORK | |
| CITY | | COUNTY | | STATE | |
| NEW YORK | | NEW YORK | | NEW YORK | |

1417 CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY ALLEGANY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY ALLEGANY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND | | | | c. LENGTH OF STAY IN 1b
6 HRS. 15 MIN. | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
MEMORIAL HOSPITAL | | | | d. STREET ADDRESS
834 WINDSOR ROAD | | | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print)
First CECIL Middle W. Last SMITH | | | | 4. DATE OF DEATH
Month FEBRUARY Day 10 Year 1960 | | | |
| 5. SEX
FEMALE | | 6. COLOR OR RACE
WHITE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
JULY 19, 1894 | |
| 9. AGE (In years last birthday)
75 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEWIFE | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Home | | 11. BIRTHPLACE (State or foreign country)
Dewight N D | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | | | |
| 13. FATHER'S NAME
WILLIAM WARD | | | | 14. MOTHER'S MAIDEN NAME
MARTHA DENNISTON | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
no | | 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT
Address
MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Congestive Heart Failure
420.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio Sclerotic Cardia
DUE TO
(c) vasculodis.
INTERVAL BETWEEN ONSET AND DEATH
1 day | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Multiple Sclerosis | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m.
19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town)
(County)
(State) | | | | | | | |
| 21. I certify that I attended the deceased from 2, 8, 1960 , to 2, 10, 1960 , that I last saw the deceased alive on 2, 9, 1960 , and that death occurred at 5:00 A.M. from the causes and on the date stated above.
ADDRESS (Street, city or town, state)
DATE SIGNED
2/11/60 | | | | | | | |
| ACTUAL SIGNATURE
W. F. Williams M.D. | | | | PHYSICIAN'S NAME (Type)
DR. W. F. WILLIAMS | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
2/12/60 | | 22c. NAME OF CEMETERY OR CREMATORY
Hillcrest Cem | | 22d. LOCATION (City, town, or county) (State)
Cumberland Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Louis Stein | | | | ADDRESS
Cumbe Md. | | 24a. REC'D BY REGISTRAR
FEB 15 '60 | |
| 24b. REGISTRAR'S SIGNATURE
Arthur L. Hines | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

ALBANY

WATERBURY

ALBANY

WATERBURY

WATERBURY

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WATERBURY

WATERBURY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01435

Reg. Dist. No.

| | | | | | | | | | | | | | |
|--|--|---|--|--|--|--|--|--|--|---|--|----------------|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Maryland</u> MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>
c. LENGTH OF STAY IN 1b <u>years</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Route 5, Miner Road</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>
d. STREET ADDRESS <u>Rt. 5, Miner Road</u>
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 3. NAME OF DECEASED
(Type or print) <u>FLORENCE</u> <u>PROFFITT</u> <u>SMITH</u> | | | | 4. DATE OF DEATH
Month <u>February</u> Day <u>7</u> Year <u>19 60</u> | | | | | | | | | |
| 5. SEX
<u>Female</u> | | 6. COLOR OR RACE
<u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>June 28, 1893</u> | | 9. AGE (In years last birthday) <u>66</u> yrs.
IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> | | IF UNDER 24 HRS.
Hours <u> </u> Min. <u> </u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Jackson County, Virginia</u> | | | | 11. BIRTHPLACE (State or foreign country)
<u>USA</u> | | | | | |
| 13. FATHER'S NAME
<u>Joseph Henry Proffitt</u> | | | | | | 14. MOTHER'S MAIDEN NAME
<u>Mary Vincent</u> | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | | | 17. INFORMANT
<u>Frank Smith, Rt. 5, Miner Rd. Cumberland, Md</u> | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
<div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> PART I. DEATH WAS CAUSED BY:
 IMMEDIATE CAUSE (a) <u>Coronary occlusion</u>
 <u>420.1</u> DUE TO
 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary sclerosis</u>
 DUE TO (c) </div> <div style="width: 15%;"> INTERVAL BETWEEN ONSET AND DEATH
 <u>Sudden</u>
 ---- </div> </div> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year <u>19</u>
Hour <u> </u> o. m. <u> </u> p. m. | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) | | (County) | | (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>Benedict Skitarelic</u> | | | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | | |
| EXAMINER'S NAME (Type) <u>Benedict Skitarelic M.D.</u> | | | | | | DATE SIGNED
<u>February 7, 1960</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | | | 22b. DATE THEREOF
<u>Feb. 10, 1960</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Rose Hill Cemetery</u> | | | | 22d. LOCATION (City, town, or county) <u>Cumberland, Maryland</u> (State) | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>John J. Hafer, Cumberland, Maryland</u> | | | | | | 24a. REC'D BY REGISTRAR
<u>DATE FEB 10 '60</u> | | 24b. REGISTRAR'S SIGNATURE
<u>Arthur S. Kraus</u> | | | | | |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1419
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
1419 CERTIFICATE OF DEATH

01436

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY ALLEGANY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY ALLEGANY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND | | | | c. LENGTH OF STAY IN 1b
1 DAY | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address)
MEMORIAL & WARWICK AVES.
MEMORIAL HOSPITAL | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First HAROLD Middle W. Last SMITH | | | | 4. DATE OF DEATH
Month FEBRUARY Day 3 Year 19 60 | | | |
| 5. SEX
MALE | | 6. COLOR OR RACE
WHITE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
JUNE 28, 1883 | |
| 9. AGE (In years last birthday)
76 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS.
Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Retired Chamber Comm Sec & Mgr.</i> | | | | 10b. KIND OF BUSINESS OR INDUSTRY
<i>Sec & Mgr.</i> | | 11. BIRTHPLACE (State or foreign country)
BATH, MAINE | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | | | |
| 13. FATHER'S NAME
COVIRTSE O. SMITH | | | | 14. MOTHER'S MAIDEN NAME
ALICE WATSON | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) no | | | | 16. SOCIAL SECURITY NO.
--- | | 17. INFORMANT
MEMORIAL HOSPITAL CUMBERLAND, MARYLAND | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Hemorrhage
DUE TO 331x
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio sclerotic vascular dis
DUE TO (c) dis
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
INTERVAL BETWEEN ONSET AND DEATH
18 hrs | | | | | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 2-2-1960 to 2-3-1960 that (I) (we) last saw the deceased alive on 2-3-1960 and that death occurred at 2:50 PM from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<i>W.F. Williams</i> M.D. | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
2/3/60 | |
| 22c. PHYSICIAN'S NAME (Type)
DR. W.F. WILLIAMS | | | | 22d. ADDRESS
Cumberland Md | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE THEREOF
2/5/60 | | 23c. NAME OF CEMETERY OR CREMATORY
Hillcrest Cem | | 23d. LOCATION (City, town, or county) (State)
Cumberland Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
<i>Louis Stein Inc.</i> | | | | ADDRESS
Cumberland Md. | | 25a. REC'D BY REGISTRAR
DATE FEB 8 '60 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
<i>Arthur S. Frank</i> | | | |

Y. H. H. H. H.

5748

57143 • 9 32 (11/05)

WATER 351A

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1420 CERTIFICATE OF DEATH

-01437

Reg. Dist. No.

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY ALLEGANY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY ALLEGANY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND | | | | c. LENGTH OF STAY IN 1b
39 DAYS | | | |
| d. NAME OF HOSPITAL OR INSTITUTION
MEMORIAL HOSPITAL
WARWICK, & MEMORIAL AVENUES | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First ROBERT Middle WORKMAN Last SMITH | | | | 4. DATE OF DEATH
Month FEBRUARY Day 7 Year 19 60. | | | |
| 5. SEX
MALE | | 6. COLOR OR RACE
WHITE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
AUGUST 15, | |
| 9. AGE (In years last birthday)
70 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS
Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Barber | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
BARTON, MARYLAND | |
| 13. FATHER'S NAME
WILLIAM SMITH | | | | 14. MOTHER'S MAIDEN NAME
MARGARET SHAW | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) | | | | 16. SOCIAL SECURITY NO.
217-30-1722 | | 17. INFORMANT
MEMORIAL HOSPITAL - CUMBERLAND, MD. | |
| 18. CAUSE OF DEATH [Enter only one cause pertaining to (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of pancreas with
157x DUE TO extensive metastasis to liver
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Since Oct 57
DUE TO (c) | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Operation 2/4/60. & above findings | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. 19 p. m. | | | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from Dec 30, 19 59 to 2-7-60 , that I last saw the deceased alive on 2-7-19 60 , and that death occurred at 8:15 P.M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE
W. F. Williams M.D. | | | | ADDRESS (Street, city or town, state)
Cumberland, MD. | | DATE SIGNED
2/8/60 | |
| PHYSICIAN'S NAME (Type)
DR. W. F. WILLIAMS | | | | 122 S. CENTRE ST., CUMBERLAND, MD. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
2/10/1960 | | 22c. NAME OF CEMETERY OR CREMATORY
Laurel Hill Cemetery | | 22d. LOCATION (City, town, or county) (State)
Moscow, MD. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
GEORGE EICHHORN, | | | | ADDRESS
LONACONING, MD. | | 24a. REC'D BY REGISTRAR
DATE FEB 11 '60 | |
| | | | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | | | |

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

ALLEGANY

INVERGLEN

ALLEGANY

ALLEGANY

GARY

GARY

GARY

U.S. FOR 1924

WINTER & RETAIL

FEBRUARY

SMITH

SMITH

SMITH

WILL

AUGUST 15

GARY, INVERGLEN

WILLIAM SMITH

U.S. CENTRAL HOSPITAL - GREENLAND, MD.

SMITH

SMITH, INVERGLEN

SMITH, INVERGLEN

SMITH

U.S. CENTRAL HOSPITAL, INVERGLEN, MD.

DR. W. F. WILLIAMS

WILLIAM SMITH, INVERGLEN, MD.

WILLIAM SMITH, INVERGLEN, MD.

1445

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Allegany</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Westernport</u> | | c. LENGTH OF STAY IN 1b
<u>11 Months</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>Kookon Nurs. Home</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
<u>Wesley Adams Snyder</u> | | 4. DATE OF DEATH
Month <u>Feb.</u> Day <u>4</u> Year <u>1960</u> | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Dec. 11, 1881</u> |
| 9. AGE (In years last birthday)
<u>78</u> yrs. | | 10. IF UNDER 1 YEAR
Months <u>78</u> Days <u>78</u> Hours <u>78</u> Min. <u>78</u> | 11. IF UNDER 24 HRS.
Months <u>78</u> Days <u>78</u> Hours <u>78</u> Min. <u>78</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Laborer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Lumber Mill</u> | |
| 11. BIRTHPLACE (State or foreign country)
<u>Pa.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>not known</u> | | 14. MOTHER'S MAIDEN NAME
<u>not known</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>no</u> | | 16. SOCIAL SECURITY NO.
<u>no</u> | |
| 17. INFORMANT
<u>Mrs. Edna Snyder-R.D. 3. Keyser, W.Va.</u> | | Address
<u>W.Va.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>442x Cardio-renal Disease</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>arterio-sclerosis</u>
DUE TO
(c) <u>Diabetes Mellitus</u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>2 yrs</u>
<u>10 yrs</u>
<u>5 years</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>November</u> , 19 <u>59</u> , to <u>Feb 4</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Feb 4</u> , 19 <u>60</u> , and that death occurred at <u>7.15 PM</u> , from the causes and on the date stated above. | | ADDRESS (Street, city or town, state) <u>Piedmont West Va</u> DATE SIGNED <u>Feb 8 '60</u> | |
| ACTUAL SIGNATURE <u>James H. Wolverton, Sr.</u> M.D. | | PHYSICIAN'S NAME (Type) <u>James H. Wolverton, Sr.</u> | |
| 22a. BURIAL, CREMATION, or REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>2/7/60</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY
<u>Waxler Cem</u> | | 22d. LOCATION (City, town, or county) (State)
<u>(Rawlings-Allegany-Md.)</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Eis. Bural</u> | | 24a. REC'D BY REGISTRAR
DATE <u>FEB 8 '60</u> | |
| ADDRESS
<u>Westernport, Md.</u> | | 24b. REGISTRAR'S SIGNATURE
<u>Arthur S. Kraus</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

01487

MANITOWISHAN DISTRICT OF HEALTH - BATHING

CERTIFICATE OF DEATH

1945

MANITOWISHAN DISTRICT OF HEALTH - BATHING

Form with multiple lines for text entry, including fields for name, date, and location. The text is faint and mostly illegible.

NAME: _____

DATE: _____

LOCATION: _____

CAUSE OF DEATH: _____

DATE OF DEATH: _____

PLACE OF DEATH: _____

AGE: _____

SEX: _____

RACE: _____

RELIGION: _____

OCCUPATION: _____

EDUCATION: _____

Marital Status: _____

Signature: _____

Witness: _____

Registrar: _____

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

01439

1421

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH
o. COUNTY ALLEGANY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE MARYLAND b. COUNTY ALLEGANY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND | | c. LENGTH OF STAY IN 1b
5 HRS. 35 MIN. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address)
MEMORIAL HOSPITAL
MEMORIAL & WARWICK AVES. | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First CHARLES Middle G. Last SOWERS | | 4. DATE OF DEATH
Month FEBRUARY Day 12 Year 19 60 | |
| 5. SEX
MALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
6-27-1880 |
| 9. AGE (In years last birthday)
79 | | IF UNDER 1 YEAR
Months 79 Days 79 Hours 79 Min. 79 | IF UNDER 24 HRS.
Months 79 Days 79 Hours 79 Min. 79 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired carpenter Contractor | | 10b. KIND OF BUSINESS OR INDUSTRY
CHANEYSVILLE, PA. | |
| 11. BIRTHPLACE (State or foreign country)
U.S.A. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
JOHN SOWERS | | 14. MOTHER'S MAIDEN NAME
GENEVIEVE HOWSER | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
219-03-8099 | |
| 17. INFORMANT
MEMORIAL HOSPITAL | | Address
CUMBERLAND, MARYLAND | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 480X DUE TO Pneumonia
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Broncho-Pneumonia DUE TO Influenza
(c) Influenza | | | INTERVAL BETWEEN ONSET AND DEATH
4 days
5-day
5 day |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Feb 7, 1960 to Feb 12, 1960 , that I last saw the deceased alive on Feb 12, 1960 , and that death occurred at 9:55 P.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE
Clay E. Durrett | | ADDRESS (Street, city or town, state)
236 Va. Av. Cumberland | |
| PHYSICIAN'S NAME (Type)
DR. CLAY E. DURRETT | | DATE SIGNED
2/13/60 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
2/15/60 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Greenmount Cemetery | | 22d. LOCATION (City, town, or county) (State)
Cumberland Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Ruth E. Silcox | | ADDRESS
Cumberland Maryland | |
| 24a. REC'D BY REGISTRAR
FEB 16 '60 | | 24b. REGISTRAR'S SIGNATURE
Arthur L. Huns | |

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2362

521

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• • •

1000

41

1422

01440

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY ALLEGANY
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND
b. COUNTY ALLEGANY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND | | c. LENGTH OF STAY IN 1b
14 DAYS | |
| d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION
MEMORIAL HOSPITAL | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First HENRY Middle STEVENSON Last | | 4. DATE OF DEATH
Month FEBRUARY Day 21 Year 19 60 | |
| 5. SEX
MALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
MAY 8, 1871 |
| 9. AGE (In years last birthday) yrs.
88 | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
RETIRED | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country)
MIDLAND, MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
ISAAC STEVENSON | | 14. MOTHER'S MAIDEN NAME
MARY MARTZ | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
(If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
WARWICK & MEMORIAL AVENUE
MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Afteriosclerotic Cardiovascular Disease
422.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 2 - 20 1960 to 2-21 1960 , that (I) (we) last saw the deceased alive on 2-20 1960 , and that death occurred at 1:45 A.M. , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
Ralph W. Ballin | | 22b. DATE SIGNED
2-21-60 | |
| 22c. PHYSICIAN'S NAME (Type)
Ralph W. Ballin, M.D. for DR. S. M. JACOBSON | | 22d. ADDRESS
62 Greene St. Cumberland, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
2/24/60 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Old Coney Cemetery | | 23d. LOCATION (City, town, or county) (State)
Lonaconing, Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
George Eichhorn | | 25a. REC'D BY REGISTRAR
DATE FEB 26 '60 | |
| ADDRESS
Lonaconing, Md. | | 25b. REGISTRAR'S SIGNATURE
William S. Kline | |

CERTIFICATE OF DEATH

1902

WILLIAM J. BRYAN

WILLIAM J. BRYAN

WILLIAM J. BRYAN

WILLIAM J. BRYAN

WILLIAM J. BRYAN

WILLIAM J. BRYAN

WILLIAM J. BRYAN

WILLIAM J. BRYAN

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WILLIAM J. BRYAN

WILLIAM J. BRYAN

WILLIAM J. BRYAN

WILLIAM J. BRYAN

WILLIAM J. BRYAN

WILLIAM J. BRYAN

WILLIAM J. BRYAN

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1452 CERTIFICATE OF DEATH

01441

| | | | | | | | |
|--|----------------------------------|---|---|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rural Flintstone | | | | c. LENGTH OF STAY IN 1b
50 Years | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Rt 3, Flintstone | | | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
Charity ^{First} May ^{Middle} Stickley ^{Last} | | | | 4. DATE OF DEATH February ^{Month} 11 ^{Day} 19 ^{Year} 60 | | | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
March 3 1883 | 9. AGE (In years last birthday)
76 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
House Wife | | 10b. KIND OF BUSINESS OR INDUSTRY
House | | 11. BIRTHPLACE (State or foreign country)
Rt 3, Cumberland, Md | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Michael Long | | | | 14. MOTHER'S MAIDEN NAME
Sally Stickley | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT Address
Mrs Daisy Stotler, Cumberland Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Thrombosis
422.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocarditis & Spermatozoa 6 mon.
DUE TO (c) Arteriosclerosis
5 yr | | | | | | INTERVAL BETWEEN ONSET AND DEATH
3 wks | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Sept 19 59 to Feb 11 1960 that (I) (we) last saw the deceased alive on Jan. 15 1960 , and that death occurred at 11 A.M. , from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
Clayton J. Jurek | | | | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) | | | | 22d. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
Feb 12 1960 | | 23c. NAME OF CEMETERY OR CREMATORY
Stickley Family Cem. | | 23d. LOCATION (City, town, or county) (State)
Flintstone, Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
William H. Kight | | | | ADDRESS
Cumberland, Md. | | 25a. REGD. BY REGISTRAR DATE
FEB 12 '60 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
Arthur L. Kline | | | |

01411

1952 CERTIFICATE OF DEATH

Allegiant

Barclay Y. Robinson

1901 Robinson

Chicago

Barclay Y. Robinson

Home

Barclay Y. Robinson

Barclay Y. Robinson

Barclay Y. Robinson

Barclay Y. Robinson

Barclay Y. Robinson

Barclay Y. Robinson

Barclay Y. Robinson

Barclay Y. Robinson

Barclay Y. Robinson

Barclay Y. Robinson

Barclay Y. Robinson

Barclay Y. Robinson

Barclay Y. Robinson

Barclay Y. Robinson

Barclay Y. Robinson

1438

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|------------------------------|---|------------------------------------|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Frostburg | | | | c. LENGTH OF STAY IN 1b
Lifetime | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Miners Hospital | | | | e. STREET ADDRESS
R. D. No 1 Box 410 | | | |
| 3. NAME OF DECEASED (Type or print)
First WILLIAM Middle P. Last THOMAS | | | | 4. DATE OF DEATH
Month Feb. Day 16th Year 1960. | | | |
| 5. SEX
M | 6. COLOR OR RACE
W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
2-19-13 | 9. AGE (In years last birthday)
46 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Charge Hand | | 10b. KIND OF BUSINESS OR INDUSTRY
Textile | | 11. BIRTHPLACE (State or foreign country)
Frostburg, Md. | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
Wm. R. Thomas | | | | 14. MOTHER'S MAIDEN NAME
Nancy Thomas Workman | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
217-10-7401 | | 17. INFORMANT
Address Mrs. Lura Thomas, R. D. No. 1, Frostburg, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 422.2 DUE TO Chronic Pneumonia
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial insufficiency - Aortic stenosis DUE TO stenosis
(c) stenosis | | | | | | INTERVAL BETWEEN ONSET AND DEATH
2 wks
2 years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from FEB 5 , 19 60 , to FEB 16 , 19 60 , that I last saw the deceased alive on FEB 16 , 19 60 , and that death occurred at 8:30 P. M, from the causes and on the date stated above.
ADDRESS (Street, city or town, state) Frostburg Md. DATE SIGNED FEB 17 1960 | | | | | | | |
| ACTUAL SIGNATURE WOMC Lane M.D. | | PHYSICIAN'S NAME (Type) WOMC Lane | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
2-19-1960 | | 22c. NAME OF CEMETERY OR CREMATORY
Eckhart Cemetery | | 22d. LOCATION (City, town, or county) (State)
Eckhart Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Sam H. Mattingly
Address Frostburg, Md. | | | | 24a. REC'D BY REGISTRAR
DATE FEB 26 '60 | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Hanna | |

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper from pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

doi:10.1017/S0022292412001906

(Purd) (Gard)

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1453 CERTIFICATE OF DEATH

01443

Reg. Dist. No.

| | | | |
|--|----------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Moscow | | c. LENGTH OF STAY IN 1b | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Moscow | |
| | | d. STREET ADDRESS
1 | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
Della First May Middle Timney Last | | 4. DATE OF DEATH
February Month 20 Day 19 Year 60 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
May 9, 1881 |
| 9. AGE (In years lost birthday)
78 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | 11. IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
House Work | | 10b. KIND OF BUSINESS OR INDUSTRY
Own Home | |
| 11. BIRTHPLACE (State or foreign country)
Barton, Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
James Fairgrieve | | 14. MOTHER'S MAIDEN NAME
Amanda Warnick | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
no | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
William Timney | | Address
Moscow, Md | |
| 18. CAUSE OF DEATH [Enter only one cause pertaining to (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pneumonia
DUE TO 491X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) Pneumococci
(c) Pneumococci | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic cardiovascular disease | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 2/15 , 19 60 , to 2/20 , 19 60 , that I last saw the deceased alive on 2/20 , 19 60 , and that death occurred at 6 M, from the causes and on the date stated above.
ADDRESS (Street, city or town, state) 221960 DATE SIGNED 2/22/60 | | | |
| ACTUAL SIGNATURE
Dr. George Vash | | M.D. | |
| PHYSICIAN'S NAME (Type)
Dr. George Vash | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
2/23/60 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Laurel Hill Cemetery | | 22d. LOCATION (City, town, or county) (State)
Moscow, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
George Eichhorn | | ADDRESS
Lonaconing, Md. | |
| 24a. REC'D BY REGISTRAR
DATE FEB 24 '60 | | 24b. REGISTRAR'S SIGNATURE
Arthur E. Thomas | |

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | |
|--|--|---|--|
| Date of Death
1900 | | Age
10 | |
| Sex
Male | | Race
White | |
| Name of Deceased
James M. Jones | | Name of Informant
James M. Jones | |
| Address of Deceased
1234 Main St.
Baltimore, Md. | | Address of Informant
1234 Main St.
Baltimore, Md. | |
| Cause of Death
Heart Disease | | Date of Death
1900 | |
| Place of Death
Home | | Signature of Informant
James M. Jones | |
| Signature of Physician
J. M. Jones | | Signature of Registrar
J. M. Jones | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01444

Reg. Dist. No.

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Allegany 1454 | | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
La Vale | | c. LENGTH OF STAY IN 1b
years | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
La Vale | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
604 Braddock Avenue | | | | d. STREET ADDRESS
604 Braddock Avenue | | | |
| 3. NAME OF DECEASED
(Type or print) HARRY JOSEPH WHETZLE | | | | 4. DATE OF DEATH February 20 19 60 | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
Feb. 25, 1888 | |
| 9. AGE (In years last birthday)
71 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS.
Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired Machinist | | | | 10b. KIND OF BUSINESS OR INDUSTRY
B. & O. Railroad | | 11. BIRTHPLACE (State or foreign country)
Baltimore, Maryland | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | | | | | | |
| 13. FATHER'S NAME
WILLIAM WHETZLE | | | | 14. MOTHER'S MAIDEN NAME
LAURA MC LANE | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
no | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Mrs. Ocle Whetzel | | | |
| | | | | 604 Braddock Avenue | | | |
| | | | | La Vale, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Occlusion
420.1 DUE TO
Conditions, if any, which gave rise to immediate cause (b) Coronary Sclerosis
(c) Coronary Sclerosis
(a), stating the underlying cause lost. DUE TO
----- | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE <i>Benedict Skitarelic</i> | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) Benedict Skitarelic, M.D. | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> February 20, 1960 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
2/23/60 | | 22c. NAME OF CEMETERY OR CREMATORY
Lutheran Cemetery | | 22d. LOCATION (City, town, or county) (State)
Harpers Ferry, West Virginia | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
John J. Hafer, Cumberland, Maryland | | | | 24a. REC'D BY REGISTRAR
FEB 24 '60 | | 24b. REGISTRAR'S SIGNATURE
<i>Arthur L. Kous</i> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01445

Reg. Dist. No.

| | | | | | | | |
|---|----------------------------------|---|------------------------------------|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Allegany 1423
b. CITY OR TOWN Cumberland
c. LENGTH OF STAY IN lb 67 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital | | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
d. STREET ADDRESS 310 Columbia St.
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print) Bertha Rebecca White | | | | 4. DATE OF DEATH
Month Feb. Day 1 Year 1960 | | | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
3/25/98 | 9. AGE (In years last birthday)
61 yrs. | IF UNDER 1 YEAR
Months Days | IF UNDER 24 HRS.
Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Homemaker | | 10b. KIND OF BUSINESS OR INDUSTRY
Own Home | | 11. BIRTHPLACE (State or foreign country)
Maryland, Cumberland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
John S. Wilkes | | | | 14. MOTHER'S MAIDEN NAME
Ella Eisenhower | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
no | | 16. SOCIAL SECURITY NO.
none | | 17. INFORMANT
Mrs. Roy Kearchner
Daughter Cumberland, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Lobar Pneumonia
DUE TO 903.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Fractured right hip (secondary)
DUE TO
(c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH
5 days
35 days | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Fractured right hip | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Fell at home in her yard | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year Nov. 26 1959
Hour 11:00 a. m. <input checked="" type="checkbox"/> p. m. <input type="checkbox"/> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Home | | 20f. (City or town) Cumberland, Alleg. Maryland
(County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Noturol causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE Benedict Skitarelic
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | | 22b. DATE THEREOF
Feb. 4, 1960 | | 22c. NAME OF CEMETERY OR CREMATORY
Sunset Memorial Park | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
John J. Hafer, Cumberland, Maryland | | | | 24a. REC'D BY REGISTRAR
FEB 4 '60
DATE | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Haas | |
| 22d. LOCATION (City, town, or county)
Cumberland, Maryland | | | | 22e. (State)
 | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1436 CERTIFICATE OF DEATH

Reg. Dist. No.

01446

| | | | |
|---|----------------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH
o. COUNTY ALLEGANY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE MARYLAND b. COUNTY ALLEGANY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
FROSTBURG | | c. LENGTH OF STAY IN 1b
LIFE | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
MINER'S HOSPITAL | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First ELMER Middle STEVEN Last WILDERMAN | | 4. DATE OF DEATH
Month FEB. Day 1 , Year 1960 | |
| 5. SEX
MALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
12-22-1895 |
| 9. AGE (In years lost birthday) 64 yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
CUSTODIAN | | 10b. KIND OF BUSINESS OR INDUSTRY
EAGLES LODGE | |
| 11. BIRTHPLACE (State or foreign country)
MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
EDW. J. WILDERMAN | | 14. MOTHER'S MAIDEN NAME
MARY ANN LYONS | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO.
215-18-8137 | |
| 17. INFORMANT
WM. WILDERMAN, FROSTBURG, MD. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Broncho Pneumonia
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) _____
(c) _____ | | INTERVAL BETWEEN ONSET AND DEATH
2 Days | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from FEB 1 , 19 60 , to FEB 1 , 19 60 that I last saw the deceased alive on FEB 1 , 19 60 , and that death occurred at 6:30 P.M. , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) Frostburg, Md. DATE SIGNED FEB 1 1960 | | | |
| ACTUAL SIGNATURE WOM Lane | | PHYSICIAN'S NAME (Type) WOM Lane | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 22b. DATE THEREOF
2-4-1960 | |
| 22c. NAME OF CEMETERY OR CREMATORY
ST. MICHAEL'S CEMETERY | | 22d. LOCATION (City, town, or county) (State)
FROSTBURG, MD. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
J. R. DURST, | | ADDRESS
FROSTBURG, MD. | |
| 24a. REC'D BY REGISTRAR
DATE FEB 5 '60 | | 24b. REGISTRAR'S SIGNATURE
Claring S. Kraus | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

10-11-19

CERTIFICATE OF DEATH

| | |
|-------------|--------------------|
| NAME | EDMUND J. WILLIAMS |
| DATE | 11-18-1935 |
| WITH | WIFE |
| PLACE | WASHINGTON, D.C. |
| AGE | 65 |
| SEX | MALE |
| CAUSE | HEART DISEASE |
| REPORTED BY | DR. J. H. HARRIS |
| SIGNATURE | [Signature] |
| DATE | 11-18-1935 |
| PLACE | WASHINGTON, D.C. |

EDMUND J. WILLIAMS
11-18-1935
WASHINGTON, D.C.
HEART DISEASE
DR. J. H. HARRIS
11-18-1935
WASHINGTON, D.C.

22a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial

22b. DATE THEREOF

Feb. 17, 1966

22c. NAME OF CEMETERY OR CREMATORY

ADDRESS

James F. Scarpelli, Cumberland, Md.

24a. REC'D BY REGISTRAR

DATE _____

24b. REGISTRAR'S SIGNATURE

REGISTRAR'S SIGNATURE
Arthur L. Krouse

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours ~~after~~ death.

VS A15 (4)
15M 10/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 01448

| | | | |
|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Frostburg | | c. LENGTH OF STAY IN 1b
10 days | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Miners Hospital | | d. STREET ADDRESS
215 Maryland Avenue | |
| 3. NAME OF DECEASED (Type or print)
Marjorie Thomas Williams | | 4. DATE OF DEATH
Month 2 Day 10 Year 19 60 | |
| 5. SEX
F | 6. COLOR OR RACE
W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Aug. 16, 1935 |
| 9. AGE (In years last birthday)
24 yrs. | | IF UNDER 1 YEAR
Months 2 Days 10 | IF UNDER 24 HRS.
Hours 19 Min. 60 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
Own Home | |
| 11. BIRTHPLACE (State or foreign country)
Lonaconing, Md. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Arthur E. Thomas | | 14. MOTHER'S MAIDEN NAME
Marjorie Bonig | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
220-32-4253 | |
| 17. INFORMANT
Dr. Lowell Williams, 215 Md. Ave. | | Address Westernport, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Massive Pulmonary Embolism
684X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) originating in Post Partum
DUE TO (c) uterus | | INTERVAL BETWEEN ONSET AND DEATH
sudden | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour 19 a. m. 19 p. m. | 20d. INJURY OCCURRED
While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE W O McLane | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) W. O. McLane M. D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> Feb. 11 1960 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
2/13/1960 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Frostburg Memorial Park | | 22d. LOCATION (City, town, or county) (State)
Frostburg, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Hafer Funeral Home | | 24a. REC'D BY REGISTRAR
Feb 15 '60 | |
| ADDRESS
25 E. Main, Frostburg, Md. | | 24b. REGISTRAR'S SIGNATURE
W. O. McLane | |

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 01449

| | | | |
|--|----------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cumberland | | c. LENGTH OF STAY IN 1b
45 yrs. | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Memorial Hospital | | d. STREET ADDRESS
107 Race St. | |
| 3. NAME OF DECEASED
(Type or print)
First Mary Middle A. Last Wilson | | 4. DATE OF DEATH
Month Feb. Day 10 Year 1960 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Nov. 24, 1874 |
| 9. AGE (in years last birthday)
85 yrs. | | IF UNDER 1 YEAR
Months 02 Days 02 | IF UNDER 24 HRS.
Hours 00 Min. 00 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
Own Home | |
| 11. BIRTHPLACE (State or foreign country)
Black Valley, Penna. | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Jesse Casteel | | 14. MOTHER'S MAIDEN NAME
Anna Offard | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]
no | | 16. SOCIAL SECURITY NO.
none | |
| 17. INFORMANT
Mrs. Chester Crabtree, Cumberland, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Chronic myocarditis, pulmonary edema
422.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic CV disease
DUE TO (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Fracture of right Hip | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Fell at home | |
| 20c. TIME OF INJURY
Month, Day, Year
6:00 p. m. Jan 25 1960 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Home | | 20f. (City or town) (County) (State)
Cumberland, Alleg. Md. | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
Benedict Skitarelic M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type)
Dr. Benedict Skitarelic, MD | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED
Feb. 10, 1960 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
2-12-60 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Oddfellows Cemetery | | 22d. LOCATION (City, town, or county) (State)
Flintstone, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
James F. Scarpelli, Cumberland, Md. | | 24a. REC'D BY REGISTRAR
DATE FEB 15 '60 | |
| 24b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | | | |

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
1447 CERTIFICATE OF DEATH

01450

| | | | | | | | | |
|--|--|--|---|---|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Frostburg, | | | c. LENGTH OF STAY IN 1b
7 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Slabtown, Mt. Savage | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Miner's Hospital | | | | d. STREET ADDRESS
1 | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print)
First John Middle Walter Last Winebrenner | | | | 4. DATE OF DEATH Month February Day 28th , Year 1960 | | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
Apr. 21st, 1907 | | |
| 9. AGE (In years last birthday)
52 yrs. | | IF UNDER 1 YEAR
Months 52 Days 28 Hours 19 Min. | | IF UNDER 24 HRS.
Hours 19 Min. | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Carman | | 10b. KIND OF BUSINESS OR INDUSTRY
W.Md.R.R.Shops | | 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
USA | | |
| 13. FATHER'S NAME
William Winebrenner | | | | 14. MOTHER'S MAIDEN NAME
Susan Hutzell | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
(If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
214-01-0123 | | 17. INFORMANT
Address Slabtown,
Mrs. Virginia Winebrenner, Mt. Savage, Md. | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 294X DUE TO Uremia
Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) Cerebral Thrombosis DUE TO (c) Polycythemia Rubra | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
76 hrs.
7 mos.
2 yrs ?? | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchial Asthma (b) Coronary Artery Heart Disease | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. 19 p. m. | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from SEPT. 1958 to 2/28 1960 that (I) (we) lost saw the deceased alive on 2/28 1960 , and that death occurred at 1 A.M. from the causes and on the date stated above. | | | | | | | | |
| 22a. SIGNATURE
Martin M. Rothstein M.D. | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
2/29/60 | | |
| 22c. PHYSICIAN'S NAME (Type)
Martin M. Rothstein | | | | 22d. ADDRESS
48 Broadway, Frostburg, Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
3-1-60 | | 23c. NAME OF CEMETERY OR CREMATORY
M. E. Cemetery | | 23d. LOCATION (City, town, or county) (State)
Mt. Savage, Md. | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Joseph R. Durst, Frostburg, Md. | | | | ADDRESS
Frostburg, Md. | | 25a. REC'D BY REGISTRAR
DATE MAR 2 '60 | | |
| | | | | 25b. REGISTRAR'S SIGNATURE
Arthur S. Huns | | | | |

01230

144. CERTIFICATE OF DEATH

Allegany, Maryland, Washington, D.C.

Stanton, Wm. H. 1890

Stanton's Hospital

Stanton, Wm. H. 1890

Stanton, Wm. H. 1890

Stanton, Wm. H. 1890

Stanton, Wm. H. 1890

Stanton, Wm. H. 1890

Stanton, Wm. H. 1890

Stanton, Wm. H. 1890

Stanton, Wm. H. 1890

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Stanton, Wm. H. 1890

Stanton, Wm. H. 1890

Stanton, Wm. H. 1890

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

01451

1426 CERTIFICATE OF DEATH

| | | | | | | | |
|--|-------------------------------|--|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY ALLEGANY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND
c. LENGTH OF STAY IN 1b 36 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES., | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND
b. COUNTY ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND
d. STREET ADDRESS 300 BEDFORD STREET
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First ELIZABETH Middle S Last ZILCH | | 4. DATE OF DEATH
Month FEBRUARY Day 16 Year 1960 | | | | | |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH OCTOBER 7 1874 | | | | |
| 9. AGE (In years last birthday) 85 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | | | | | |
| 11. BIRTHPLACE (State or foreign country) CUMBERLAND, MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | |
| 13. FATHER'S NAME JOHN SCHILLER | | 14. MOTHER'S MAIDEN NAME ELIZABETH LOWENSTEIN | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. None | | | | | |
| 17. INFORMANT Jeanette Bonig, Cumberland, Md. | | Address | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchopneumonia, diffuse
DUE TO 204.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Pulmonary abscess Right upper lobe
DUE TO 6 days
(c) Chronic Lymphocytic Leukemia
unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Hypertensive Heart disease
INTERVAL BETWEEN ONSET AND DEATH 6 days | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/> | | | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 7 Jan 1960 to 16 Feb 1960 , that (I) (was) last saw the deceased alive on 16 Feb 1960 and that death occurred at 10:15 AM from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Louis Michael Glick M.D. | | 22b. DATE SIGNED 17 Feb 60 | | | | | |
| 22c. PHYSICIAN'S NAME (Type) Louis Michael Glick | | 22d. ADDRESS Smallwood St. Cumberland, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 2/19/1960 | | | | | |
| 23c. NAME OF CEMETERY OR CREMATORY Rose Hill Mausoleum | | 23d. LOCATION (City, town, or county) (State) Cumberland, Md. | | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Byron Kight ADDRESS Cumberland, Md. | | 25a. REC'D BY REGISTRAR DATE FEB 23 '60 | | | | | |
| 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus | | | | | | | |

ALLEGANY

270 58

(473)

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